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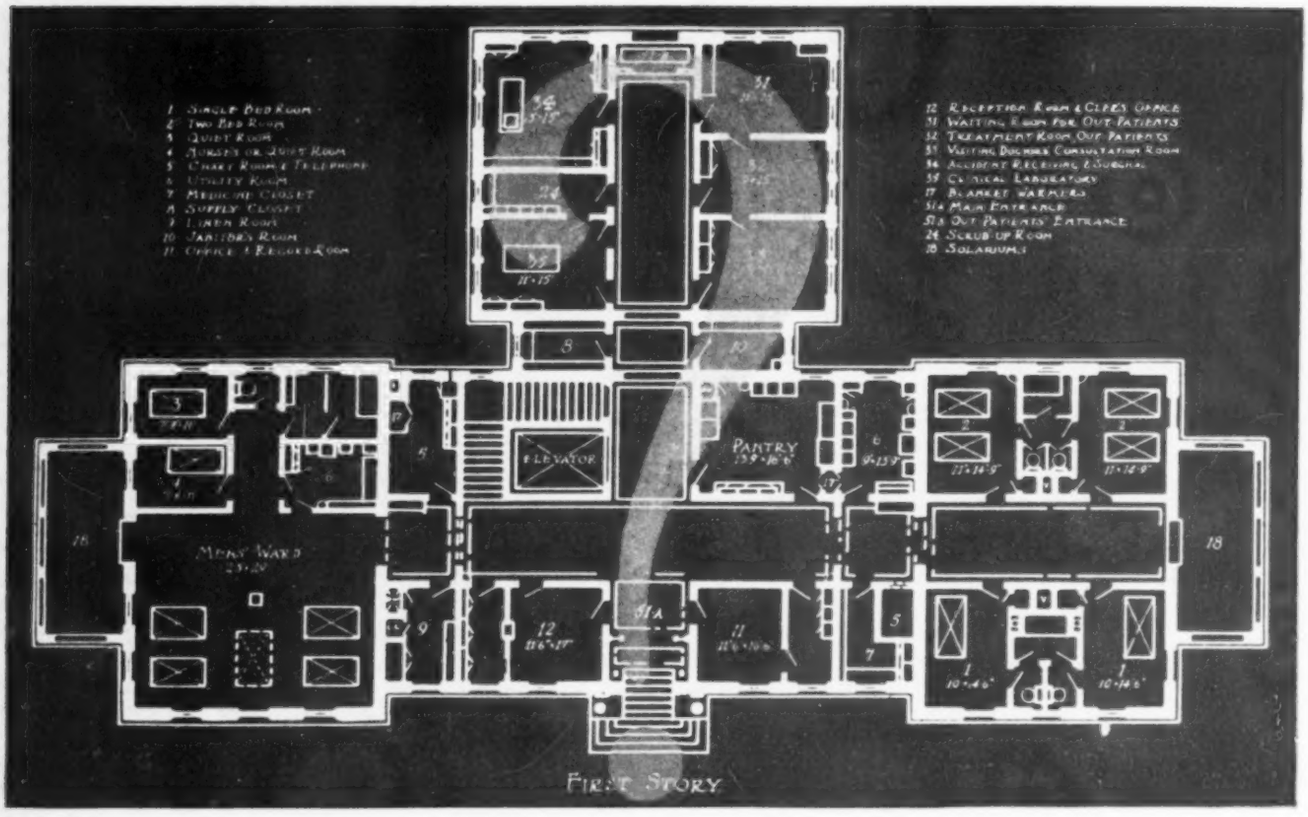

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HOSPITAL PLANNING AND CONSTRUCTION IN 1924

By S. S. GOLDWATER, M.D., Director, Mount Sinai Hospital, New York.

A DISPOSITION to seek the very best in hospital construction, coupled with the rather sad conviction that, at the moment, conscientious adherence to such a policy involves prohibitive costs, characterizes the current attitude of hospital building committees. Again and again one is asked: "What is the best hospital in the United States?" Building committees want to know what is best, even though they are unable to adopt it. The question is, of course unanswerable, for I doubt whether anyone, in this huge country of ours, is able to maintain a sufficiently wide contact with hospital activities to justify an attempt to answer the question. The question, too, implies a universally accepted standard. William Wetmore Story once said that "there was never anything written, painted, or chiseled which is not full of defects; the question is whether, in spite of those defects, it is good." In hospital planning and construction, as in every other art, one must expect to find, in a variety of mixtures, the good, the mediocre, the bad, and the impossible.

Examples of Bad Planning

An example of the impossible is presented by a scheme for the extension of an existing hospital of 150 beds, which shows a new wing, containing private rooms and wards, only twelve feet distant from an existing ward wing. Another example of the disregard of fundamental values in hospital planning is presented in a scheme for the erection of two special hospitals (affiliated with a university group) only ten feet apart.

The temptation to do these things often arises from a desire to find the easiest way out of a difficult problem; it is so much easier to utilize land which is already available than it is to find a new site. The influence of hotel and apartment house architectural practice on hospital design, is another important factor, for the chairman of a hospital building committee who is familiar with hotel construction and planning is apt to think in terms of such construction when formulating a hospital program. In like manner, the great industrial magnate who has learned the value of standardization in factory construction, is likely, without fresh investigation or analysis, to carry his conclusions over into the field of hospital construction, where they may not apply at all.

The domination of hospitals by great captains of industry has yielded, in our times, strikingly contrasting results. On the one hand we have the example of a powerful industrial personality dictating the planning of a nurses' home which in its extravagant generosity of design is beyond the wildest dreams of the most ambitious educator of nurses; this princely gesture can be followed by hospitals of limited resources only by imperilling their solvency. On the other hand we encounter a brilliant organizer of "big business" who is convinced that the only proper way to build a group of hospital buildings is rigidly to standardize the framework of the entire group (without regard to diversified hospital needs) and ruthlessly to eliminate every vestige of individual form, esthetic design, and domestic decoration. With such examples before us, it seems proper to remark that hospitals have distinctive functions, and that the planning of complex hospital buildings is a suitable task for those who have made an intimate study of hospital requirements, and who have the skill to mould buildings to meet these requirements economically. A standard unit of construction which can be advantageously utilized for the multiform serv-

ices of a general hospital is yet to be devised.

The financial difficulties which have been encountered by huge hotel-hospitals projected during the past year will give pause to capitalists who have been rashly disposed to move into an investment field which has not yet been thoroughly surveyed. The promoters of such enterprises usually make the mistake of assuming, in their financial calculations, that huge hotel-hospitals can be fully rented summer and winter. Another fatal error is made when it is assumed that a first-class hospital can be erected at a cost per unit of space no greater than that of an apartment house. The ultimate wreck of any hotel-hospital scheme which rests on such flimsy financial foundations as these, is inevitable.

We must not forget, however, that the first impulse toward the creation of these huge private hospitals came from the widely voiced demand for moderately priced hospital accommodations for private patients. The phrase "moderately priced" in this connection usually connotes room rates which, as hospital accountants know, are barely sufficient to cover the operating expenses of a hospital which is exempt from taxation, and which does not need to earn interest on its capital investment. Whether or not private patients are entitled to be received in hospitals on such terms is a question of social ethics or policy. From the standpoint of the present article, it is to be observed that the loud demand for moderately priced private accommodations continues, and that it has resulted during the past year in the introduction into private pavilion plans of many small individual rooms, and of an increasing proportion of semi-private wards accommodating two, three, or four paying patients.

The Tendency Toward Small Ward Units

A desire to subdivide large public wards into smaller units continues to influence hospital planning. Comparatively few wards containing more than sixteen beds have been planned during the past year; in several instances 16-bed or 24-bed wards have been sub-divided by fixed screens into bays accommodating four beds each. In recent ward planning the advantage of locating the nurses' station just outside of the ward proper has been generally recognized.

Costly experience in the operation of hospitals occupying widely scattered buildings has taught hospital superintendents to favor highly concentrated building schemes. But careful analysis of the precise effects of lateral or ground concentration in a given case is not always made, and sometimes the concentration idea is overworked. The ten, fourteen, or eighteen-story building that affords no facilities for outdoor treatment except the roof, usually overloads its elevator service and crowds into cramped roof space many patients of diverse social classes, giving comfort and satisfaction to nobody. In these multi-storied hospitals, too, there is a disposition to place the two most active service units, namely, the kitchen

New Jewish Hospital, St. Louis, Mo., one of the large hospitals erected during 1924.

and its accessories, and the operating rooms and laboratories, at the upper and lower extremities of the great vertical mass. In this manner the desired concentration and convenience are not achieved. Architects would do well to compare this hospital type, with its inflexible floor plan and its long vertical transportation lines, with a type consisting of three connecting buildings—patients' units to the right and left, and a combination service unit of appropriate and individual shape in the center, the latter connecting with the patients' units at their middle. The administration or service unit at the center may be built in such a manner that extensions to it are possible, an opportunity which is lost in the uncompromising office-building cube. The results of planning along this line will be apparent in several hospitals to be completed during the coming year.

Types of Specialized Hospitals

Among specialized hospitals for the treatment of acute diseases there are only two types that are holding their ground as entities, namely, the children's and the maternity hospital. While, however, specialized maternity hospitals are growing in number and size, the proportion of maternity cases cared for in general hospitals is increasing; the implantation of maternity units in general hospitals calls for the thoughtful arrangement of interiors, especially with respect to sound transmission from labor rooms and nurseries.

The inclusion of wards for contagious cases in general hospitals is a disputed question. One cannot wonder at the raised eyebrows of hospital architects who, in Philadelphia, encounter a stringent regulation of the local department of health against the retention of any contagious patient in any voluntary hospital, and in New York a sanitary code that requires every general hospital to be prepared to isolate and care for contagious patients whose condition might not warrant the risks of a journey to a municipal hospital. Few sanitary authorities to-day endorse the position of Philadelphia in this matter. Most general hospitals do not, of course, clamor for permission to take care of contagious cases; the desire to include contagious wards in a hospital scheme is most commonly encountered in teaching hospitals. A notable example of modern practice is that of a children's hospital, affiliated with a medical school, which has under construction an 8-story building for 200 children; the topmost story of the building is divided into four flexible contagious units. The nurses in charge will occupy rooms in the general nurses' home.

Impetus has been given to the construction of hospitals for crippled children by the generous and ambitious program of certain benevolent organizations which have become interested in the care of crippled children. For these hospitals one- and two-story building schemes are the rule.

Noises without and within the hospital must be reckoned with more than ever, as street traffic grows more boisterous and the framework of buildings more rigid. In hospital buildings of many stories additional elevators increase alarmingly the production and transmission of noises. The omission of air spaces and of cinder-concrete fill between floor and ceiling aggregates the danger. In a hospital now under construction, the customary inch and a half or two-inch cinder-concrete floor fill, in which electric conduits may be conveniently imbedded, and which, to a certain extent, interrupts the transmission of sound from floor to floor, has been omitted. If the omission of this fill necessitates the subsequent application to the finished ceiling of sound-absorbing material, the desired economy will scarcely have been attained.

Due Appreciation of Fire Hazards

Due appreciation of fire hazards is responsible for a large part of the reconstruction which is now going on. While extreme hazards in existing buildings are tolerated by many local government authorities, the hospitals themselves are learning to take their responsibilities seriously and are making many improvements and replacements to reduce or eliminate the danger. It would be well for the hospitals of the United States to adopt as their goal the elimination of all non-fireproof hospital buildings over two stories in height. For new construction this standard is now generally required. Unfortunately, certain building and fire departments have adopted regulations which call for the needless multiplication of fire stairs and fire towers. They do not appear to understand that a strictly fireproof hospital ward building contains so little movable equipment of an inflammable character as to nullify the danger of any widespread conflagration. The introduction of a superfluous fire tower of the out-and-in variety, for example, in a seven-story ward building, results on each floor of such a building in the absorption (and waste) of sufficient space and material to accommodate at least two patients. This is a great pity, because the loss of fourteen hospital beds in a building of this type is equivalent to the loss of from $70,000 to $90,000 of community funds.

Many contracts for hospital construction have been placed during the latter part of 1924 on unexpectedly favorable terms. I have before me a

communication stating that a contract for the erection of a composite hospital building, containing outdoor departments, x-ray rooms, physiotherapy department, drug department, etc., which, on the basis of experience during the earlier part of the year, was expected to cost seventy-five cents per cubic foot, has been awarded to a responsible contractor at sixty-six cents per cubic foot. Another recent example is that of a hospital addition estimated by the architect at $325,000, for which a bid of $250,000 was received.

The Search for Economies

The search for economies in hospital construction never ceases. A new partition tile, designed as a substitute for terra cotta block, is obtainable in sizes four and one-half by nine inches, and six by six inches, and is three and one-fourth inches thick. The surface is finished in a matt glaze of any color. A vitrified surface is also made. Through the use of this material, a considerable saving is claimed as against ordinary terra cotta block faced with wall tile; the saving is variously estimated at from twenty to thirty cents per square foot. One obstacle to the use of this new double faced tile is that the interior spaces are not large enough to hold plumbing pipes. The question of noise transmission has given some concern to the makers, and it is recommended that the tile be split where the avoidance of the transmission of noise from room to room is desired. The split tile, however, requires reinforcement by iron rods, and the repair of a partition wall thus reinforced would be difficult, yet such repairs might be called for to gain access to the pipe spaces between the split tiles forming the two sides of the partition. Notwithstanding this drawback, the product is an extremely interesting one; its practicability is likely to be enhanced and the cost of its production diminished by its more extensive adoption.

Hard and soft floors have been extensively used during the past year, separately and (in the case of wards and corridors) in combination. The floor materials most extensively used in hospitals are terrazzo, tile, rubber, linoleum, and cement. Where linoleum or other applied material is placed over concrete, a new form of binding strip or bar, designed to protect the edges of the concrete and to form a good binding for the linoleum or other material used, has been found advantageous.

Fuel Oil Installations Increase

The number of fuel oil installations has increased. The economy of oil as compared with coal is not everywhere apparent, though favorable reports in respect to cost may be obtained from certain cities. Oil is often preferred because of strong desire to avoid the handling of ashes.

The attention of equipment concerns has lately been concentrated on bedpan washers. The separation of the two processes of (a) emptying and washing the bedpan, and (b) sterilizing it, seems to be quite generally approved, though combination washers and sterilizers have not been altogether abandoned. An entirely new form of bedpan washer, designed to be built into the wall, and leaving only a hinged cover exposed, was one of the most interesting exhibits at the Buffalo convention of the American Hospital Association.

The volume of steam arising from utensil and instrument sterilizers has long been a source of annoyance. The customary method of treatment has been to introduce a vent of liberal diameter. A condensing device is now available as a substitute for the vent. In this apparatus, an ejector is employed, using a fine spray of cold water, which draws steam from the sterilizer and condenses it at the same time.

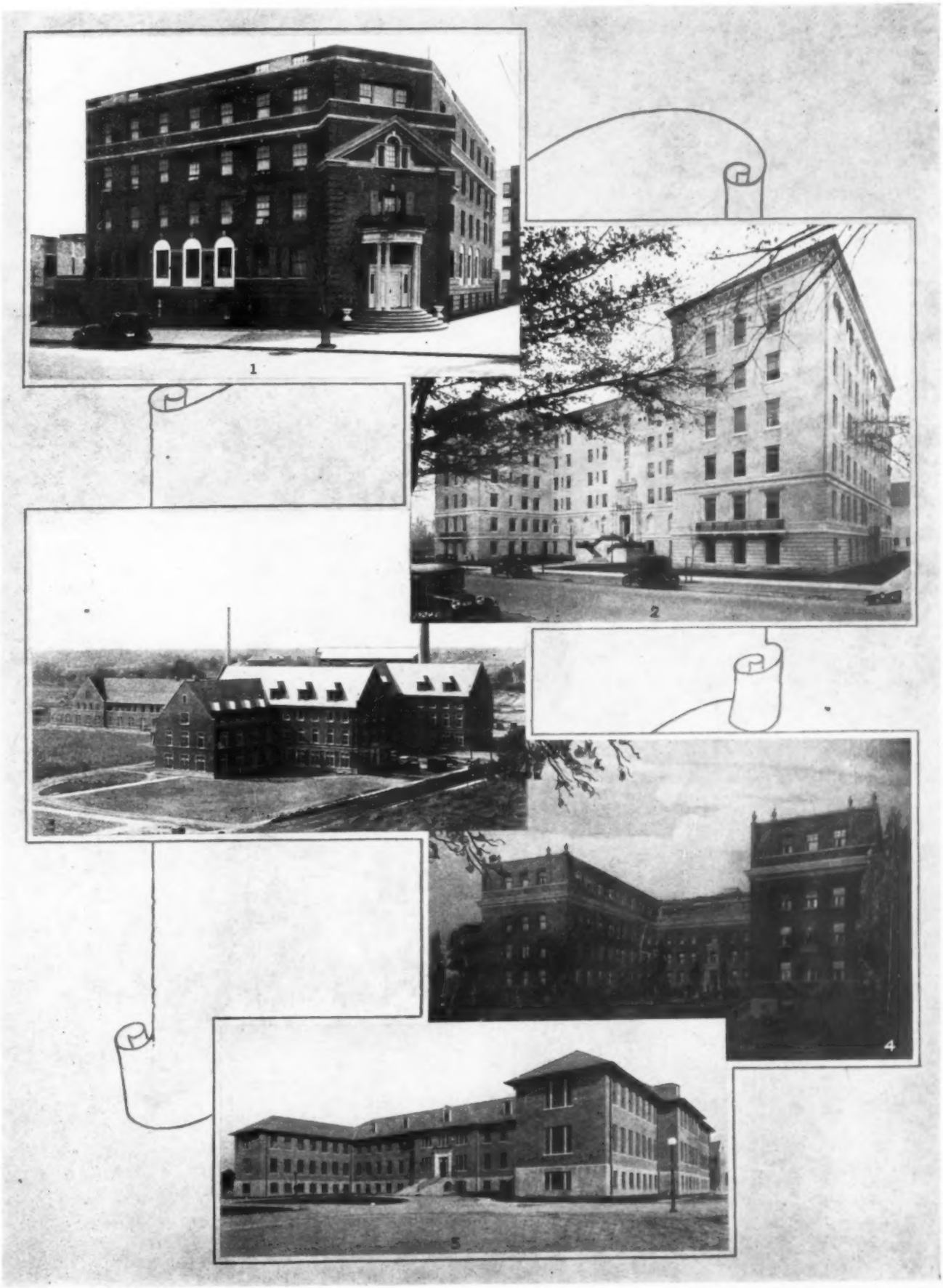
Skylights Less in Demand

A disposition to abandon operating room skylights is noticeable, especially in industrial cities in which clean air is practically unknown, and where a slanting skylight becomes covered with soot within a few hours after washing. The hopelessness of any attempt to keep a skylight clean in certain manufacturing cities is obvious. It should not be too hastily assumed, however, that surgeons have lost all interest in daylight. The best that can be claimed for artificial light in an operating room is that it is a close imitation of daylight; in this respect great advances have lately been made in artificial lighting. It may be worth while to cite the actual practice of surgeons in a busy hospital in New York City, where the atmosphere is relatively clean, and where clear bright days are frequent. In one hospital a record was made of the use or non-use of artificial light in 100 operations performed at various hours between 7 a. m. and 7 p. m. during the month of October, when the days are neither long nor short. In 100 cases, artificial light was used sixty-nine times; daylight was preferred thirty-one times. In a test made elsewhere during the same period, it was found that out of 140 operations ninety-seven were performed with the aid of artificial light and forty-three without it.

For the construction of examining room screens, ward cubicles, etc., standard metal units are now obtainable at prices comparable with the price of special wood construction.

(*Continued on page 10*)

LARGE HOSPITALS OPENED DURING 1924



(1) Hunt's Point Hospital, New York, N. Y.; (2) Sutter Hospital, Sacramento, Calif.; (3) James Whitcomb Riley Hospital, Indianapolis, Ind.; (4) addition, Bethesda Hospital, Zanesville, Ohio; (5) Main Hospital building, U. S. Veteran's Hospital No. 100, Camp Custer, Mich.

HOSPITAL ADMINISTRATION DURING 1924

By A. C. BACHMEYER, M.D., Superintendent, Cincinnati General Hospital, Cincinnati, Ohio.

IN THIS age of industrialism and science, the "machine age" as many style it, the years seem to pass with ever increasing rapidity. As we review the work of the year just closed, it seems all too short a time to indicate any particular progress or development in any one field of human endeavor. No one event emerges to call particular attention to steady progress that is evident in the realm of institutional management. A constantly growing number of hospitals are availing themselves of modern methods in administration and, through improvements in organization, equipment and physical arrangements, are striving for a higher degree of efficiency in performing the service for which they have been established. In general, we may safely say that hospitals are performing a higher, more competent and more adequate type of service than ever before. The fact that the endeavor to improve the service continues unabated is a significant healthy symptom.

Internal Developments

THE hospital laboratory department received more attention during the past year than ever before, and it is now generally recognized that no hospital can function as it should without well-equipped laboratories manned by trained personnel."

"The development of radiation therapy through the use of radium, higher voltages in the x-ray and by means of exposure to the sun's rays, has also produced a number of improvements and innovations in hospital facilities and equipment."

"The past year indicated that the trend of thought concerning hospitals is rapidly undergoing a change. The general public no longer regards them solely as institutions for the care of the sick and injured but as definite factors for the promotion of health and the social welfare of the community."

National Hospital Day, May 12, was more generally celebrated than in previous years and is now an established institution. This year its initiators turned over the responsibility for its continuance to the American Hospital Association and thus to the entire hospital field. The inauguration and celebration of this day has been of exceeding benefit in the way of bringing hospitals to public attention. It is to be hoped that more and more institutions will participate in its observance.

Attention Centers Around Laboratories

The established success and consequent further development of "insulin therapy," the many advances made in blood chemistry and other diagnostic measures were responsible for the establishment of new and improved laboratory facilities. This department of the hospital received more attention during the last few years than ever before, and it is now generally recognized that no hospital can function as it should, without well-equipped laboratories manned by trained personnel.

The "insulin therapy," more than any other single factor, was also responsible for many advances in our dietetic laboratories and, consequently, in improved conditions in the entire dietary department. Attention is being focused upon this very important phase of institutional activity, to the benefit of all patients.

The development of radiation therapy through the use of radium, higher voltages in the x-ray and by means of exposure to the sun's rays, has also produced a number of improvements and innovations in hospital facilities and equipment during the last year. Today all of these methods of treatment must be taken into consideration by the hospital administrator, if his hospital is to keep abreast of progress.

The conference of the American Hospital Association, always one of the high-lights of the year for the hospital executive, held in Buffalo last October, was generally conceded to be the best convention the association has ever had. The exposition was the largest, and was more interesting and instructive than any previous exposition. The various sectional and general meetings were replete with information for the executives in attendance. The many and valuable contributions made in the reports of the several committees were of solid worth to every one interested in the phases of administrative procedure covered. The presence of the representatives of England and of New Zealand was an out-

standing feature of the conference. It is always of interest to know what others in similar, though isolated, fields of endeavor are doing, and their contributions brought to us the realization that our problems and ambitions are shared in foreign countries. Their presence focused our attention on the work that is being done for the health and welfare of mankind across both the Atlantic and the Pacific oceans.

A declaration of purpose in the form of a pledge and creed was presented and recommended for adoption at the conference. This creed should be of assistance to every executive in promoting a better morale among the hospital personnel. Its message is succinct and definite and it embodies an ideal for every hospital employee. In this age when "things are in the saddle," it is well to uphold the ideal of "service" and to emphasize the fact that substitutes may be more readily found for all of the material things of life than for the great ideals that have come down to us through the ages. It is in these basic motives that civilization finds the impetus for its progressive development.

Front view of the new addition to St. Luke's Hospital, Chicago, Ill.

Financial problems continued to be difficult, since no single solution was or can be proposed. Emphasis was again placed upon the necessity for better control of finances through the use of the budget system. The urge was felt in many instances for careful study to eliminate waste, for the better coordination of departments, for the establishment of definite schedules of procedure and through research, analysis, compilation and comparison of data for more accurate and economical control of financial affairs. In an endeavor to find a way to increase income, pleas for increased endowments and, in some instances, for an increase in the rates charged the full-pay patient were submitted in order that services might be extended for those unable to pay full rates. In the instances where "community chests" and "hospital funds" exist, campaigns for funds were, for the most part, successful. In some instances, those responsible for the "chest" or "fund" felt that hospital authorities were no longer feeling a personal responsibility for hospital finances and they were seeking some solution for this problem. These organizations likewise voiced the desire for a more accurate and equitable method of determining contributions to hospitals, as they feel that to underwrite the deficit is not, in every instance, just to themselves or to the hospitals.

Little change in cost of operation and maintenance was experienced in comparison with that made in 1923. As in that year, there was some decline in prices of commodities during the early months, followed by a rise the latter part of the year. It was reported that commodity prices advanced about nine per cent between July 1 and December 1. The level of prices at the close of the year was relatively high. The general improvement in industrial conditions was reducing the number of unemployed toward the end of the year. In a number of localities this fact together with restricted immigration gave rise to a labor problem. Labor costs maintained their previous level. The advances made in diagnostic methods and therapy together with the continued high price level was responsible for an upward trend in the curve of hospital costs.

A number of excellent articles, dealing with various phases of hospital administration were published during the year. Two of the most helpful publications appeared in the form of books upon the subjects: *First Steps in Organizing a Hospital* and *Hospital Organization* and *Operation*, by Mr. J. J. Weber, editor, THE MODERN HOSPITAL, Chicago, Ill., and Mr. Frank E. Chapman, superintendent, Mount Sinai Hospital, Cleveland, Ohio, respectively. These two volumes are among the most valuable contributions to the hospital field last year.

The question of the training of hospital executives continued to attract attention. Temple Uni-

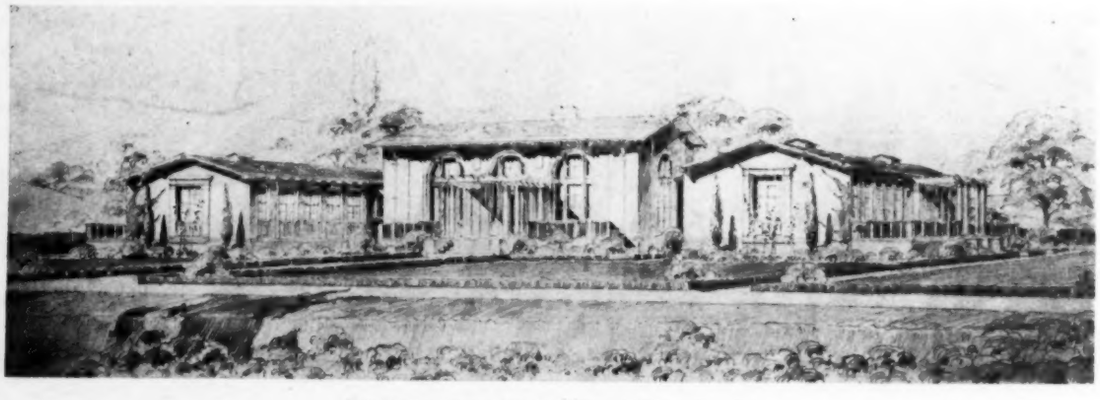
versity in Philadelphia conducted a summer course for executives and established an evening course during the fall. A college for the training of hospital executives was also opened last fall, under the auspices of the Catholic Hospital Association, at Marquette University, Milwaukee, Wis., on the same educational basis as the other colleges of that university. The demand for training is still evident and we turn our faces toward 1925, hopeful that further progress will be made.

Change in Public Attitude Toward Hospitals

The past year indicated that the trend of thought concerning hospitals is rapidly undergoing a change. The general public no longer regards them solely as institutions for the care of the sick and injured but as definite factors for the promotion of health and the social welfare of the community. It is true that the hospital has become the one place where all of the agents developed by modern medicine are concentrated and where they can be made effective for the benefit of the patient. This is the natural result of scientific achievement and the public has not been slow to realize the value of hospital service. It is also realizing that many of the diagnostic methods and other scientific advances are of value as preventive measures. Through the clinic or out-patient department the hospital comes into contact with the patient before his illness is entirely disabling and is able, in many instances, to modify or entirely prevent a period of total disability.

The last few years have witnessed marked advances in preventive medicine and industrial hygiene. It is in the dispensary that measures seeking to prevent sickness and promote health may best be introduced. Infant welfare stations, in which mothers are given advice concerning the care and feeding of well babies, are found in many communities. This type of service should be extended to all age groups. Considerable advance was made in this direction during 1924, and it is hoped that the coming year will witness the further development of pre-natal, well baby, and other health clinics, all having a similar purpose in that they endeavor to reduce the incidence of disease and promote better health conditions in the individual, the home, the factory and the community. The addition of such functions brings the hospital into closer relationship with the community and enables it to perform the greatest measure of service.

Shriners' Hospital for Crippled Children, St. Louis, Mo.



Del Valle Farm for Children, Livermore, Cal.

FOUR CHICAGO HOSPITALS HAVE TWO-MINUTE TAXI SERVICE

Two minute taxi service has been made possible to four of Chicago's largest hospitals through the installation of "ticker" call boxes service so that all the hospital attendant is required to do is to pull the lever on the messenger box. This instantly records on a tape and bell in the nearby agent's office from which a cab is immediately dispatched. This service is identical with that used by the Western Union and Postal Telegraph companies to summon messengers immediately. Chicago is the first city in the world to use call boxes for this purpose. The hospitals which are now using this service are Mercy Hospital, Wesley Memorial Hospital, Chicago Memorial and St. Luke's Hospital. If the system proves valuable it will be installed in other hospitals.

A REVIEW OF THE WORK OF THE A. H. A. DURING 1924

By JOHN E. RANSOM, Acting Secretary, American Hospital Association, Chicago, Ill.

THE year 1924 was one of steady, consistent growth for the American Hospital Association. In membership, in influence, and in service to the hospital field, marked progress has been made. More and more the advice and approval of the association concerning hospital policies and procedure are being sought by members, both institutional and personal. The work of the office of the association in the collecting and disseminating of hospital data, in answering requests for information and counsel, in the preparation, publication and distribution of bulletins, proceedings and the like, has very greatly increased.

One of the outstanding features of the year was the launching of a membership campaign through regional committees covering the entire hospital field of the United States and Canada. The association has an ambition to build up its membership to the point of including every eligible hospital and hospital worker in the two countries. The membership campaign represents a further step towards that goal. Thus far it has produced a very gratifying result, particularly in the increase of institutional members.

In 1923 the constitution was amended to provide for "subscribing memberships," that is, memberships of hospitals located outside of continental North America. In 1924 the first of such memberships was established.

The association, through the action of its board of trustees, assumed responsibility for the further promotion and development of National Hospital Day. The need for more adequate publicity in their respective communities is being increasingly recognized by hospitals everywhere, and National Hospital Day, fostered and promoted by the American Hospital Association, bids fair to become a potent factor by which hospitals may acquaint their communities with their service and their needs for greater public interest and support.

As the association develops, there come increasing cooperative relationships with other organizations in the general health field. During the year, two committees of the association have worked with committees of the American Medical Association and the American Public Health Association in the consideration of problems related to intern service and to the interrelationships of hospitals and health department.

The committee on general furnishings and supplies has been cooperating with the division of simplified practice of the United States Department of Commerce in the matter of standardization of hospital beds and bed blankets.

Noteworthy work was done during the year by several other special committees, particularly those on cleaning; on buildings-construction, equipment and maintenance; and on foods and equipment for food service. The reports of these committees cover in detail matters which are of great interest and value to many hospitals. They will be published as special service bulletins of the association.

Milestones of the Year

ONE of the outstanding features of the year for the association was the launching of a membership campaign through regional committees, covering the entire hospital field of the United States and Canada. . . . Thus far it has produced a very gratifying result, particularly in the increase of institutional members." The association, through the action of its board of trustees, assumed responsibility for the further promotion and development of National Hospital Day."

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The Exposition—An Index to Progress

In many ways the most obvious index of the development of the association is the annual conference and exposition. The 1924 conference was the best attended meeting in the history of the association. The program was generally conceded to have excelled that of any previous conference in variety of subjects presented and in

the number of members and delegates participating in discussions. But perhaps more significant than a large attendance and a rich and varied program was the splendid spirit which permeated the gathering. As some one said, the enthusiasm of those who attended the Buffalo conference seemed to indicate a growing consciousness on the part of the membership of the association of the organization's opportunities and responsibilities.

The attendance and participation of delegates and guests from several foreign countries at the conference was indicative of the increasing prestige of the association.

The exposition was the largest, most comprehensive and best ever assembled. It was easy to note the progress that has been made in making this feature of the annual conference essentially educational in character. The day of the exposition as a market seems definitely to have passed, and with the change it is likely that its value to both the association and to the exhibiting firms has been enhanced.

Taken as a whole, the year 1924 witnessed a greater realization of the ideals of the association to promote the welfare of both the sick and well through the development of more efficient hospital service.

Hospital Planning and Construction in 1924

(*Continued from page 4*)

In a backward glance over the year that has passed, two things seem to stand out most clearly. The first is that the people of the United States are deeply interested in worthy, non-commercial hospital projects, and stand ready to come to their support in a most generous way; again and again the results of building fund drives have exceeded expectations. The second is that program-making in a large sense—planning with an eye to future needs which are plain to the prophetic eye—is happily becoming one of the commonplaces of hospital planning.

HOSPITAL AND DISPENSARY DEFINED

The Ohio State Board of Health had defined the words "hospital" and "dispensary" for the purpose of registration, as follows:

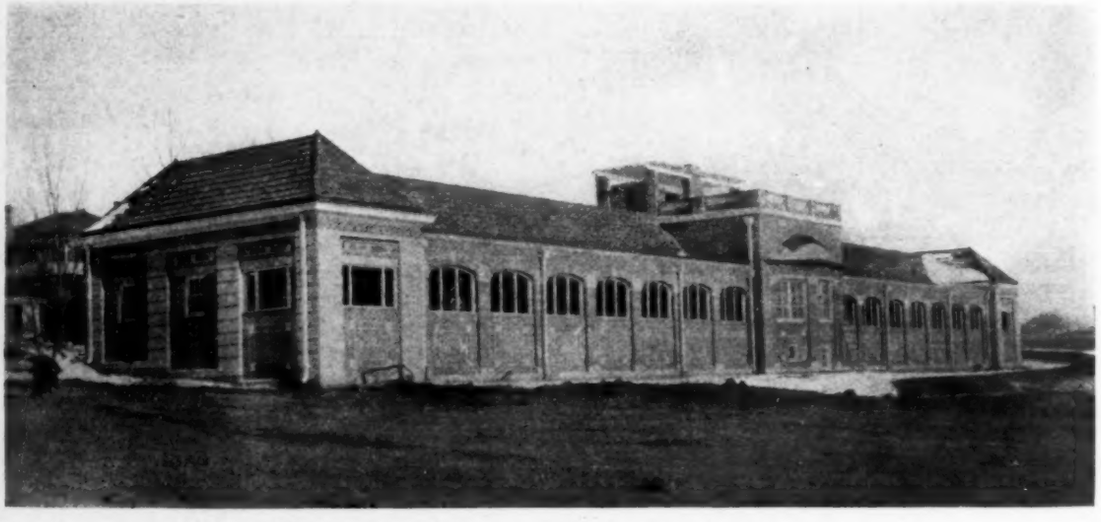
"Any institution or establishment, public or private, for the reception and care of persons for a continuous period longer than twenty-four hours, for the purpose of giving advice, diagnosis or treatment bearing upon the physical or mental health of such person, shall be considered a hospital."

"Any institution or establishment, public or private, for the purpose of giving advice, diagnosis or treatment bearing upon the physical or mental health of an individual shall be considered a dispensary; provided that a hospital and the quarters of a licensed practitioner of medicine used for his private practice shall not be deemed to come within the meaning of this definition."

MIDWEST STATE HOSPITALS ORGANIZE

An association to be known as the Midwest State Hospital Association has been formed by the state hospital representatives from Kansas, Nebraska, Missouri, and Oklahoma, who recently met for the purpose of bringing this type of hospitals into closer relationship.

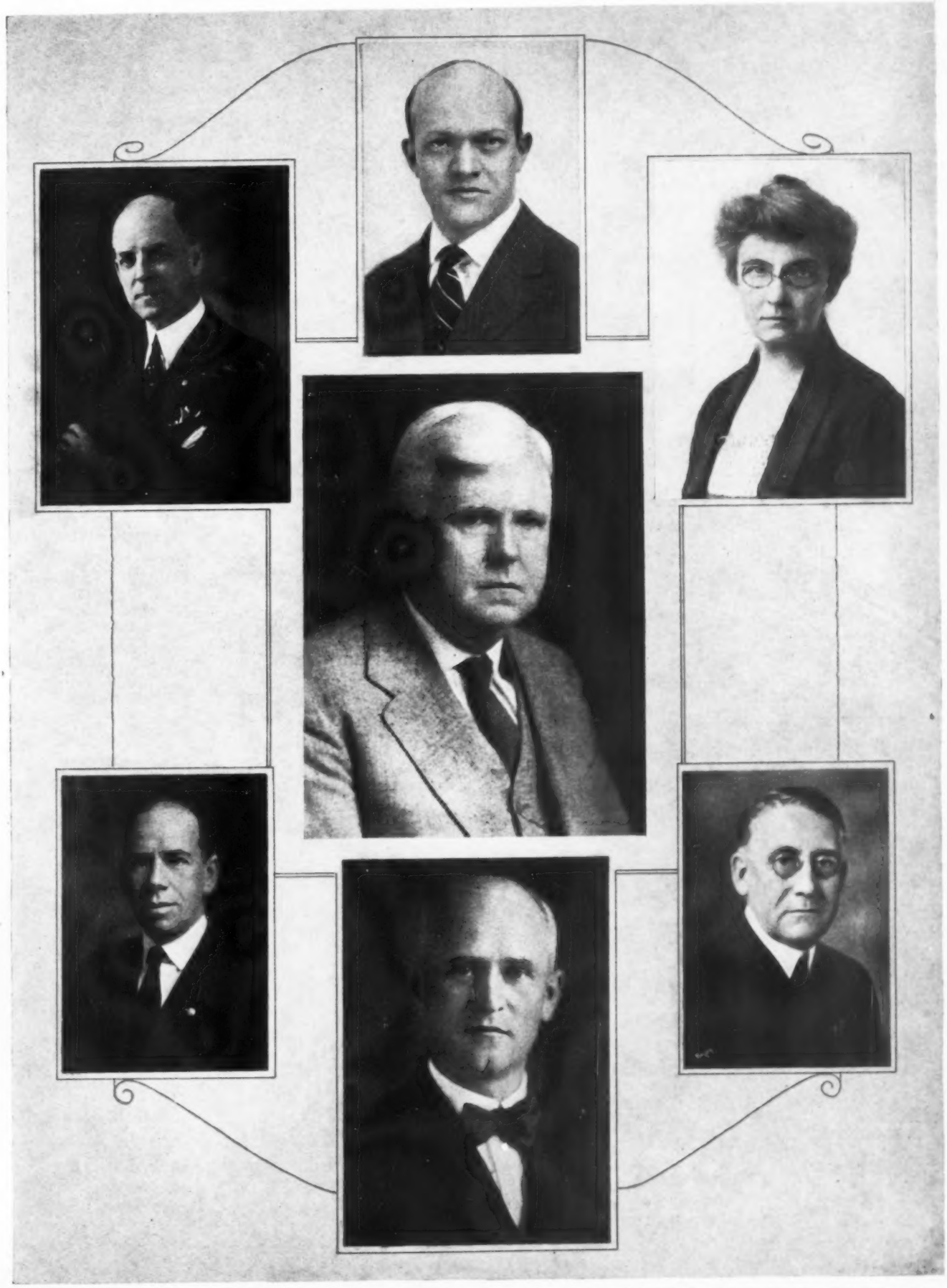
Officers were elected at the gathering and it was decided to hold a meeting of the association in St. Joseph, Mo., in the spring. Col. W. P. Fulkerson, president, board of managers, State Eleemosynary Institutions, Jefferson City, Mo., was elected president. The other officers are Dr. William S. Fast, superintendent, Hastings State Hospital, Ingleside Neb., vice-president, and Dr. F. A. Carmichael, superintendent, Osawatomie State Hospital, Osawatomie, Kan., secretary-treasurer.



New patient's pavilion, Swedish National Sanatorium for Tuberculosis, Denver, Colo.

The state commission for studying the number and needs of crippled children in the state of New York of which Senator William T. Byrne, Albany, is chairman, has appointed Mr. Henry C. Wright, New York, director of the survey, and has established its headquarters in room 315 Capitol, Albany. The commission will report in February.

NEW OFFICERS OF AMERICAN HOSPITAL ASSOCIATION



(Upper row, left to right) Mr. Robert Jolly, first vice-president; Dr. A. C. Bachmeyer, president-elect; Miss Evelyn H. Hall, second vice-president; (center) Mr. E. S. Gilmore, president; (lower row, left to right) Dr. Nathaniel W. Faxon, third vice-president; the late Dr. A. R. Warner, executive secretary; Mr. Asa S. Bacon, treasurer.

HOSPITAL ACTIVITIES IN THE CANADIAN PROVINCES DURING 1924*

EXPANSION in building programs and improvements in existing hospitals, development of government relations to hospitals and broader cooperation of public health and hospitals are some of the signs of progress in the hospital field of the Canadian provinces during 1924.

Perhaps one of the most outstanding developments in the entire Canadian field during the year has been the erection of the new Civic Hospital, at Ottawa, Ont., a project which bids fair to make that city the hospital as well as the governmental center of the Dominion. The new Civic Hospital now completed, replaces the Protestant General Hospital, St. Luke's Hospital, and the Ottawa Maternity Hospital and provides facilities for the care of 600 patients. The physical plant of this new institution is one of the finest on the continent.

At Kingston, Ont., the Kingston General Hospital is engaged in the planning of a program of expansion under the director of the Bureau of Municipal Research of Toronto.

A significant factor in hospital development is the new reception hospital for the care and treatment of psychopathic cases at Toronto, which is to be opened this month. This new hospital which was built by the city of Toronto and which will be equipped by the city and the Ontario government and operated and maintained by the province will meet the demand which has been urgent for some time in Toronto, for the proper care of the psychopathic cases in general hospitals.

Other developments in Toronto hospitals are the New East End Hospital which is now in the process of erection, the enlargement of the outpatient department of the Toronto General Hospital as well as a new building for the x-ray department, and the inauguration of a diabetic dining room for in-patients as well as transcient diabetics.

A progressive step was taken by Ontario hospitals in the reorganization of the Ontario Hospital Association which held its first annual meeting in Toronto, October 2 and 3, 1924. The legislative committee appointed at that meeting is now working upon some legislation vital to Ontario hospitals. The committee held its first meeting October 31 when the problem of municipal support of hospital work was studied and the recommendation made that the act requiring each municipality to pay fifty cents per diem per capita towards the maintenance of all patients for which the hospital receives from all other sources not more than $1,50 per diem, be changed so as to require a per diem contribution of seventy-five cents from the province and $2.00 per diem from the municipality, for all patients for whose maintenance the hospital receives an amount not exceeding $2.75 per diem. The committee also recommended that the Workmen's Compensation Board be required to meet the full cost of hospital maintenance upon all cases under its charge.

An advancement in nursing education was made by the Ontario Nurses' Registration Act which became effective November 1, 1924. Under the provisions of the act the hospitals of Ontario will be required to meet a higher standard of nurse training, and graduates who fail to conform with the regulations in the act will be denied registration in the province. The act not only imposes certain standards of nurse education, but undertakes to assist the smaller hospitals in arranging necessary affiliation for its nurses in order that all schools may meet the requirements of the act.

Canadian Progress in 1924

ACTIVITIES in the Canadian provinces during the year have been marked by a greater unity of feeling on the part of hospitals in the individual provinces. This progress was evident at the annual meetings of the various hospital associations where definite steps were taken toward the betterment of hospital service in line with the requirements set forth in the minimum standard of the American College of Surgeons.

An effort is also being made to improve the educational standard of nursing and to provide affiliation between the larger and smaller schools.

Facilities are rapidly being improved, as is witnessed by the widespread enlargement of existing institutions and programs of expansion now under way.

*For the information furnished as the basis of this article, THE MODERN HOSPITAL is indebted to the following Canadian hospital executives: Dr. A. K. Haywood, superintendent, Montreal General Hospital, Montreal, Que.; Mr. W. W. Kenney, superintendent, Victoria General Hospital, Halifax, N. S.; Dr. F. C. Middleton, director, division of child welfare and hospital management, Saskatchewan Department of Public Health, Regina, Sask.; Dr. H. R. Smith, medical superintendent, Royal Alexandria Hospital, Edmonton, Alta; Dr. George F. Stephens, superintendent, Winnipeg General Hospital, Winnipeg, Man.; Dr. F. C. Bell, superintendent, Vancouver General Hospital, Vancouver, B. C.; and Mr. C. J. Decker, superintendent, Toronto General Hospital, Toronto, Ont.

In Quebec hospital activities have centered around the promotion of provincial government aid. In Montreal, as a result of the formation of the General Health and Tuberculosis League of that city, the provincial government has opened a tuberculosis sanatorium at Lake Edward, and negotiations are in progress for the reopening of the Laurentian Sanatorium at St. Agathe, also an institution for the treatment of the tuberculous. These two events are of significance because, until this action was taken by the government, tuberculous work in the province was practically at a standstill.

The Hospital for the Incurables, Cartierville, which was destroyed by fire early in the year, is being rebuilt on a larger scale in order to provide adequately for incurables in the province.

During the past year the Catholic population of Montreal has erected St. Mary's Hospital which is the beginning of a larger unit sponsored by the Catholics of that city.

As in Ontario, attention is centered on the problem of the Workmen's Compensation Act which is receiving close study. A royal commission was appointed last winter to investigate the subject and it is hoped that when its study is completed it may result in more financial assistance to hospitals in employment cases. At the present time the Workman's Compensation Act of the province provides only for the payment of first aid to hospitals for injured employees and makes no provision for remuneration to the physician or surgeon in charge.

Although there were no outstanding developments in the hospital field in British Columbia, general progress was evidenced at the meeting of the British Columbia Hospital Association held at Victoria last August.

Nursing Progress in British Columbia

In the field of nursing increased demands are being made by the nursing organizations which will probably call for a more extensive and reciprocal arrangement for the affiliation of the smaller training schools with all the larger hospitals. The course leading to the degree of bachelor of science in nursing offered by the University of British Columbia continues to attract an increasing number of students.

There have been no extensive building programs during the year, but a number of additions to existing plants are in the process of construction. A receiving department has been added to the Provincial Mental Hospital, New Westminster, and a new wing is under construction for the Royal Jubilee Hospital, Victoria. A modern hospital unit of 200 beds for the treatment of infectious diseases is being planned at Vancouver. A district laboratory is to be opened at Kamloops as a part of the program of provincial health authorities.

The seven hospitals of 100 beds and over received the approval of the American College of Surgeons.

Governmental Changes in Manitoba

A significant change in governmental relationship with hospitals has been made in the province of Manitoba where the hospitals have been brought under the government department of the municipal commissioner instead of under the department of agriculture and immigration, as was formerly the case. Hospital inspection is provided for by the appointment of a member of the provincial board of health who will act as inspector instead of the inspector of public institutions who heretofore held this position.

As a part of the government's general program for the care of mental cases, the Manitoba Hospital for Mental Diseases at Selkirk has a new receiving unit which will accommodate seventy-four patients. At the Brandon Hospital for Mental Diseases, Brandon, a reception building is being constructed which will provide for 110 acute cases.

Definite progress is reported in nursing education, as higher entrance requirements are genally being adopted and pressure is being brought to bear upon educating the student nurse. In general, hospital service continues to improve. The influence of staff meetings is being felt throughout the province and the necessity of keeping adequate records is being widely accepted.

Legislative Changes in Alberta

In the province of Alberta activities have centered around concerted action against legislation unfavorable to the hospitals of the province. On June 30, the Department of Public Health of the Province of Alberta issued a number of additions to the regulations of the Hospital Act which have met with opposition from the hospitals of the province. A resolution was adopted at the convention of the Alberta Hospital Association, held November 12 and 13 at Edmonton, which advocates the arrangement of a conference between the Department of Health and representatives of the Alberta College of Physicians and Surgeons and the hospitals of the province with a view toward the revision of the regulations in question. It also asks that the Department of Public Health be asked to suspend the operation of these regulations until such a conference has taken place.

In Nova Scotia there have been a number of

developments in the expansion of hospital facilities. At Dalhousie University, Halifax, a public health center has been established in close connection with the hospital and medical college which establishes at the hospital, an out-patient service for teaching purposes for the medical school.

The Victoria General Hospital, Halifax, has made extensive improvements in its laboratory buildings. In Antigonish the old St. Martha's Hospital is being replaced by a new $200,000 modern hospital.

Activities in the hospital field in Saskatchewan during 1924 centered around governmental supervision of hospitals. The sixth annual convention of the Saskatchewan Hospital Association was held at Regina, September 3 and 4, where fifty-five delegates from hospitals of the province discussed the problems which have grown out of governmental legislation and supervision.

A protest was voiced in the form of a resolution against the provision of September, 1923, which required nurses in training to take, prior to graduation, a three months' course in a sanatorium. The resolution requests that this be not enforced. A resolution was also passed urging the Department of Public Health to remedy the prevailing situation of no adequate provision for the aged and infirm who are not proper hospital cases, since the provincial government is responsible for the care and treatment of such patients.

WESTCHESTER COUNTY ASSOCIATION PLANS INSTITUTIONAL TOURS

A program of visits to various allied institutions is being planned for this year by the Westchester County Hospital Association, the society composed of hospital superintendents, directors of nurses and those in co-relation throughout Westchester County, New York.

The entire group will visit institutions such as the State Prison at Ossining, various administrative and medical institutions at Ellis Island, county hospitals and homes, such as Grasslands Hospital, Valhalla, and the State Hospital for the Insane, Poughkeepsie. The visits planned offer a complete study of institutional procedure along definite diversified channels.

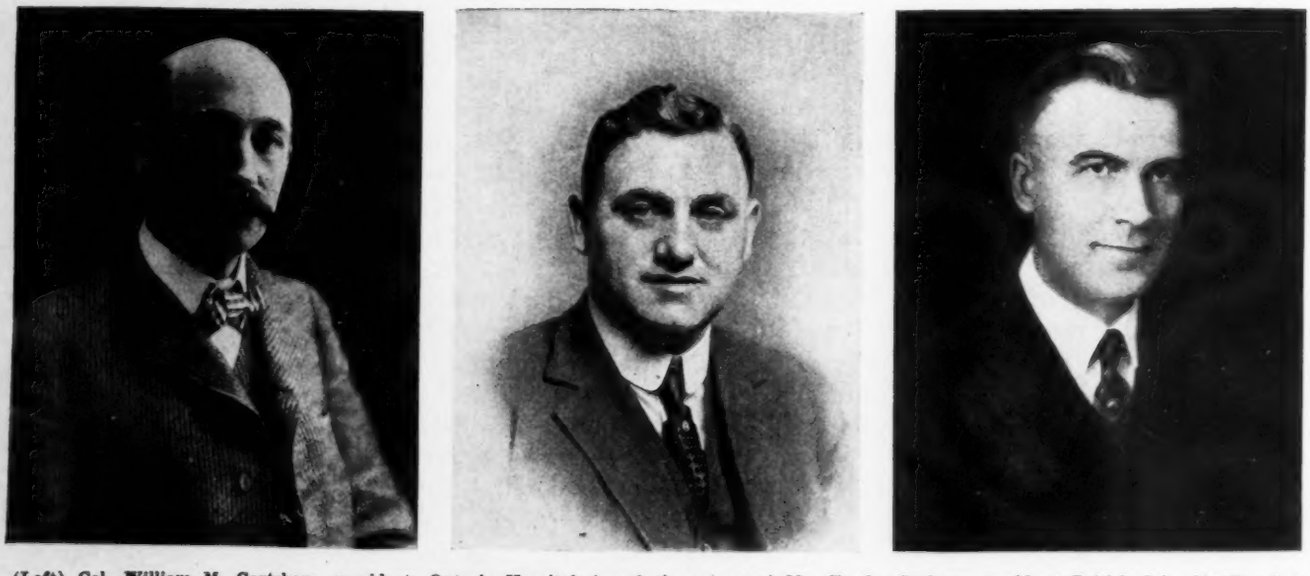
The association meets monthly at the Hotel Brevoort, New York City. It aims to promote cooperative relationship and to coordinate the institutions of the county and through the broader vision it inculcates in its members, to make more effective their ideal of service to their respective communities and to the county at large. It aims to have men and women of prominence in hospital and allied fields present at the monthly meetings to bring distinct messages to the members.

Mr. Edgar C. Hayhow, superintendent, New Rochelle Hospital, has been appointed new president of the association. The other officers are: vice-president, Miss B. A. Bamber, director of nurses, Grasslands Hospital; secretary and treasurer, Miss Marjorie Thompson, Dobbs Ferry Hospital; and chairman in charge of the nursing division, Miss Mary E. Land, superintendent, Mount Vernon Hospital, Mount Vernon.

APPORTIONMENT OF EXPENSES FOR THE UNITED HOSPITALS, NEW YORK

An analysis of the expenses of the United Hospitals, New York City, for 1923 shows that professional care of patients, including medical and surgical supplies, x-ray, laboratories and service, cost $4,448,462, or 25 per cent of the total. Food, kitchen, laundry, cleaning took $6,472,267, or 37 per cent. General house and property expenses amounted to $2,853,909, or 16 per cent. Out-patient work called for $1,981,286 or 11 per cent. Corporation expenses were three per cent and administration costs $1,281,183, or eight per cent of the total.

OFFICERS OF CANADIAN HOSPITAL ASSOCIATIONS



(Left) Col. William M. Gartshore, president, Ontario Hospital Association; (center) Mr. Charles Graham, president, British Columbia Hospital Association; (right) Mr. George E. Patterson, president, Saskatchewan Hospital Association.

HOSPITAL ACTIVITIES OF THE AMERICAN COLLEGE OF SURGEONS DURING 1924

By M. T. MacEACHERN, M.D., Associate Director, American College of Surgeons, Hospital Activities, Chicago, Ill.

DURING the year 1924 the American College of Surgeons completed the seventh survey of hospitals in the United States and Canada. The list of approved hospitals for 1924 published in the November issue of THE MODERN HOSPITAL shows the result of: (1) the seventh survey of hospitals of one hundred beds and over; (2) the third survey of hospitals of fifty to one hundred beds; (3) the preliminary survey of (a) hospitals of thirty-five to fifty beds (b) national homes for disabled volunteer soldiers, (c) marine hospitals of the United States Public Health Service. During the year, twenty-one hospitals in New Zealand, Australia, and Hawaii were also visited.

Hospital standardization, a movement for hospital betterment, though carried on actively for only seven years, has made outstanding progress, as shown by the following statistics:

1924

(A) Approved hospitals of 100 beds and over—
- Number of hospitals surveyed..... 961
- Number of hospitals approved..... 837
- Percentage 87.1

(B) Approved hospitals of 50-100 beds—
- Number of hospitals surveyed..... 973
- Number of hospitals approved..... 513
- Percentage 52.6

(C) Approved hospitals of 35-50 beds—
- Number of hospitals surveyed..... 307
- Number of hospitals approved..... 50
- Percentage 15.9

(D) Summary for 1924—
- Total number of hospitals surveyed.....2366
- Total number of hospitals approved.....1427
- Average percentage for the United States and Canada (50 beds and over)..... 69.7

(E) Summary—

(1) Seven surveys of hospitals 100 beds and over:

Year	Hospitals Surveyed	Hospitals Approved	Percentage
1918	692	89	12.9
1919	692	198	28.6
1920	692	407	58.8
1921	761	573	75.3
1922	812	677	83.4
1923	870	751	86.2
1924	961	837	87.1

(2) Three surveys of hospitals 50-99 beds:

1922	812	335	41.3
1923	916	430	46.9
1924	973	513	52.6

Standardization Progress

THE hospital program of the American College of Surgeons as expressed in the minimum standards has developed rapidly and taken firm root in the hearts and minds of the people of America. The movement has become its own propagandist, for it has proved its worth. ....The requirements are universally recognized, since they aim at focusing the hospital's attention directly on the patient...."

"In many instances we find the dishonest, unethical fee-splitting doctors driven from the larger, well-regulated approved hospitals and carrying on in the smaller institutions unchecked and uncontrolled in their professional work. The only remedy for this condition is to have these institutions standardized also, in order that such doctors can be eliminated or properly controlled. There is urgent need for this today."

The hospital program of the American College of Surgeons as expressed in the minimum standard has developed rapidly and taken firm root in the hearts and minds of the people of America. There is an increasing demand for it from all quarters. The movement has become its own propagandist, for it has proved its worth. The program is definite, its requirements reasonable, its methods of presentation acceptable. The requirements are universally recognized, since they aim at focusing the hospital's attention directly on the patient. This means much to the 12,000,000 patients annually passing through the hospitals of the United States and Canada.

Cooperation in Standardization

Hospital standardization, in its few years of existence, has accomplished much for better hospital service. This is due in no small part to the keen interest and cooperation manifested, not only on the part of the hospitals themselves, but also of the medical and nursing professions, the public and the numerous allied organizations in the field, national, state, provincial and local.

During the year the utmost cooperation and assistance has been forthcoming from the Council

on Medical Education and Hospitals, the American College of Physicians, the American Society of Clinical Pathologists, the various radiological associations, the American, the Catholic, the Protestant and the Methodist Hospital Associations, the Central Council for Nursing Education, and other national, state, provincial and local allied organizations, as well as numerous governmental departments.

Early in the year requests to include their respective groups of hospitals in the survey were received from the Board of National Homes for Disabled Volunteer Soldiers, the United States Public Health Service, the United States Veterans' Bureau, and more recently from the medical departments of the United States Army and the United States Navy respectively.

It is only through whole-hearted interest and cooperation of this kind that much can be accomplished by the college while, on the other hand, the college is anxious to cooperate with the various groups mentioned and be of any service it can to them.

Standardization and the Small Hospital

The college is firmly of the opinion that there is a real work to do for the group of hospitals of twenty-five to fifty beds. Many reasons can be put forth for this.

There has been an ever increasing demand, not only from the hospitals themselves, but also from the public, for the college to extend the hospital betterment movement and service to the group of institutions of twenty-five to fifty beds, since about fifty per cent of the people, it is stated, live in the rural communities and the larger percentage of these institutions are found there. It is reasonable to claim that these hospitals serve a worthy group who are entitled to efficient hospital service.

Hospitals in this class have more professional difficulties proportionately than do the larger ones. Not only are there deficiencies in professional service due, in some cases, to lack of first-hand knowledge, but occasionally there exist jealousies among the profession which tend to diminish cooperation, consultations, etc. Under these circumstances the college has already been of constructive assistance.

In many instances we find the dishonest, unethical fee-splitting doctors driven from the larger, well-regulated approved hospitals and carrying on in the smaller institution unchecked and uncontrolled in their professional work. The only remedy for this condition is to have these institutions standardized also, in order that such doctors can be eliminated or properly controlled. There is urgent need for this today.

From daily experience it is well known that there are many emergency or acute surgical cases which are not safely transportable. There is, therefore, a very urgent need to have these smaller hospitals adequately organized and equipped to deal with such cases. Many hospitals of twenty-five to fifty beds lack scientific facilities and are having financial difficulties. The college can frequently help solve this problem by bringing about better team-work and cooperation between the larger and smaller institutions or between the hospital and the state or province in services such as x-ray and clinical laboratory. Grouping of these services can be done at a great financial economy. The problem for each institution, however, must be worked out on its own merits. This can best be done by the college representative through his personal visit.

Thus through a service of this kind, the college can be a factor in making available better hospital service for the mass of people. To this end the college has this year made a preliminary survey of all the hospitals of thirty-five to fifty beds in the United States and Canada.

Standardization and the Future

From the experiences of the past seven years the college finds it advisable and necessary to visit the hospitals annually in order to insure the best and most permanent results. The personal visit of the representative each year does much to keep the hospitals up to the standard and affords an opportunity for constructive aid in solving many of the more intricate professional problems that, from time to time, arise. To this end an endeavor has been made to visit all the hospitals of fifty beds or over again this year.

The college further realizes that no survey can be carried on successfully without giving concurrently an extensive background or supporting service. Accordingly the Hospital Information and Service Department has been organized during the early part of the year. The work of this new department has grown rapidly and in the first ten months of its operation served, 1,042 institutions seeking information and assistance in the solving of their problems and in increasing the efficiency of the institution. This service is rendered through carefully edited letters or articles of information compiled at headquarters, through abstracted authoritative information and package libraries sent out on loan. The department has been able to give the field a much quicker service than formerly. On very urgent occasions a preliminary wire giving data in abstract may precede the package library in order to expedite matters.

The service is free to any hospital upon request.

There have been ever-increasing demands of various kinds made on the college during the year, which have been met so far as it was physically and financially possible. The attendance and interest at the hospital conference of each sectional meeting has greatly increased, and early in the series of meetings it was found necessary to extend the program to the second day. A large number of round-table conferences have thus been held, affording all the hospital people an opportunity to discuss their problems informally.

In giving serious thought to the present and future development of the hospital standardization program the college feels that the time has now arrived when greater thought must be directed to (1) the giving of more attention by the hospitals to follow-up and end-results, (2) the developing of minimum standards for the various clinical services and departments in hospitals. This year the college has emphasized these two matters particularly, in the numerous sectional meetings held in the United States and Canada, and will continue to stimulate more interest in them.

It is most gratifying to note that greater attention is being paid to "follow-up and end-results" in hospitals today. This is the only way in which we can make a real appraisal of the work and properly compare statistics. No institution can be conducted in a comprehensive manner without close follow-up of all patients discharged and periodic interpretation of end-results.

The hospitals today are looking for standards and especially such as are minimum and practical. Valuable service can be rendered by the college in submitting carefully worked out minimum standards. It is the earnest desire of the college in this work that the institutions standardized will not be satisfied with merely meeting the minimum but will go on ever increasing in efficiency until the maximum is reached.

During the past year a minimum standard for fracture service in hospitals was established. This standard was submitted by the fracture committee of the American College of Surgeons after extensive investigation and subsequent study of data received through carefully selected regional sub-committees in all parts of the United States and Canada. This standard has been very well received throughout the field. The following are the recommendations by the committee.

After extensive investigation and subsequent study of data received through carefully selected regional sub-committees in all parts of the United States and Canada, the general committee on fractures of the American College of Surgeons, has submitted the following as a minimum in the treatment of fractures:

A. That all general hospitals be equipped to care for fractures; that the minimum equipment for the transportation and emergency treatment of fractures be the following or its equivalent:
   1. Thomas upper extremity splints
   2. Thomas lower extremity splints with traction straps, slings and buckle straps
   3. Hodgen splints
   4. Coaptation splints, assorted sizes
   5. Cabot wire splints
   6. Straight pieces of wood (of assorted length, width and thickness) for splints
   7. Plaster of Paris bandages
   8. Some form of overhead frame for suspension
   9. Suitable x-ray apparatus, including a portable machine, if practicable.

B. That it is highly desirable that one individual surgeon be responsible for the supervision of the care of fractures in each hospital service.

C. That special record sheets be used for fracture cases.

More recently a minimum standard for history taking has been recommended by the committee on history review of the college and has been presented in the field.

The college has attempted in its program, and will attempt in the future, to stimulate more interest in the organization and administration of clinical departments in hospitals. The programs of the sectional and general meetings include interesting papers and discussions on the essentials for the organization and administration of such special departments as surgery, medicine, ophthalmology, oto-laryngology, obstetrics and other services. It is hoped that minimum standards may in time be established for these as a guide in hospital service and development.

The new Vermillion County Hospital, Clinton, Ind.

ELECTIVE COURSE IN SOCIAL SERVICE

A three months' elective course in hospital social service has been added to the curriculum of the New York Hospital training school. The convalescent phase of this study was begun at the admission department of the Burke Foundation where a short history of convalescence was given and admission methods studied.

"A Record of 1923," the year book of the Sheffield (England) Joint Hospitals' Council, has been received. The book contains 118 pages of text and illustrations attractively presented.

A REVIEW OF THE PROGRESS OF NURSING AND NURSING EDUCATION IN 1924

By LAURA R. LOGAN, President, National League of Nursing Education, Chicago, Ill.

IN securing information from the various states to supply definite facts, as a basis for this review, it is evident that the greatest progress in nursing has occurred in those states in which there have been secured good nurse registration laws, where sufficient appropriation is available to provide for adequate inspection of the schools by a well-prepared nurse who is director of the department and where, too, the nurses of the state, in their organizations, cooperate with the state department in an effort to raise standards of nursing education. It is true that a number of states have had registration laws for a long period of years but that actual growth from year to year is hardly apparent, while in a number of others a steady growth has been reported from year to year. States showing conspicuous growth in the past year through the efforts of the state department of education are Wisconsin, New York, Ohio, Virginia, Pennsylvania. The District of Columbia has been very active in raising the standards of its schools, but in this case the League of Nursing Education is largely responsible for the growth.

Students Replaced by Graduates

One encouraging sign observable in a few states is the tendency on the part of smaller hospitals to see the folly of attempting to conduct a school of nursing with the meagre facilities which they possess. During the year, in several of the states, a number of smaller hospitals have closed their schools and are providing graduate nurse service supplemented by nursing aides.

A tendency to employ more graduate nurses and attendants in the hospitals where schools of nursing are maintained, has generally resulted in stabilizing the nursing service, and making it possible to arrange for the student nurse a definite and systematic program of classroom work, bedside instruction and nursing practice.

Most encouraging is the almost universal report that there is an increase in the number of students entering schools of nursing and also an increase in the percentage of those who are high school graduates. One director of a state department of nursing education writes, "Our schools of nursing are full of students. The number of preliminary educational certificates issued in the first ten months of the year 1924 shows an increase of 150 over the same period for the previous year."

To arrange for periods of affiliation to round out the preparation of the student nurse is becoming an accepted policy. Especially is this true in the services of pedatrics, medicine and public health nursing. It is noticeable that contagious diseases and tuberculosis are being included in this list in some states almost as rapidly as the schools are able to find hospitals adequately staffed and equipped to receive their nursing students. It is true also that in several states but few schools are making efforts to secure this training for their students, chiefly because no higher authority exacts it and, as always in the past, the need of the home hospital holds a paramount place in the minds of the school authorities. The idea that the knowledge of the care and treatment of communicable diseases is basic in the education of the nurse has not yet been accepted in all the states. This year, to Ohio may be credited the largest percentage of schools preparing their students in communicable disease nursing.

Affiliation in Pediatrics Receives Impetus

Affiliation in pediatrics has received a special impetus in several states during the past year. In fact a steady growth in affiliation maintained by schools all over the country is reported. In New York State, for example, 121 schools out of a total of 143 maintain affiliation. In other words, only twenty-two have been able to satisfy the state department that they have sufficient clinical material in all types of nursing service for the adequate training of the nurse. Following is the list of affiliated services which New York State is now requiring:

Schools affiliating for pediatrics	99
Schools affiliating for medicine	58
Schools affiliating for obstetrics	38
Schools affiliating for nutrition	10
Schools affiliating for mental nursing	5
Schools affiliating for surgery	18
Schools affiliating for public health nursing	3

The New York State Department reports affiliation outside the state in order to provide conditions favorable to the education of the nurse. Affiliation in communicable diseases and tuberculosis is conspicuously absent from the list of affiliations maintained in New York state. The state department of nursing education expresses itself as unwilling to approve any affiliation until the hospital facilities in those institutions in which affiliation is sought, be made comparable to those maintained in the hospitals in which are the registered schools of nursing of

the state; that the type of instruction, supervision and general upkeep and repair, technique, etc., be on a par with that provided in the home school.

Training in Mental Nursing

Many of the states offer no opportunities whatever for education in mental nursing, and in those few states which maintain institutions where instruction in psychiatry and neurology may be secured under adequate conditions, but a small percentage of the schools of nursing are taking advantage of this opportunity. This is particularly true in Illinois where, under the auspices of the state, a very good school of psychiatric nursing offers affiliation. This school reports but few schools taking advantage of this laboratory in mental hygiene. There is evidence, however, in more than one state that the nurses are becoming alive to this basic need in the curricula of their schools. During the year there was formed in the Ohio State Association of Graduate Nurses a committee whose mandate was to make recommendations to the state department of public welfare, to the end that the mentally ill in the state should have more adequate nursing care and that at least one properly equipped mental hospital be furnished by the state for the education of the student nurse in mental diseases in order to make a demonstration. This committee has secured the cooperation of the mental hygiene committee of the state medical association. The committee of the medical association will make a similar appeal to the department of public welfare. The progress in the field of mental nursing is slow for the reason that until comparatively recently this type of nursing had been neglected in the basic preparation of the nurse (as given in most schools) with a few notable exceptions. Consequently, the number of nurse instructors prepared to work in this nursing service is comparatively few.

A number of states report a decided increase in the number of full-time and better prepared instructors employed in the schools of nursing.

Affiliations in Various States

During 1924 a number of schools in several states have secured affiliation in certain courses with their local universities. In Wisconsin a combined preliminary course, under Marquette University, including Marquette University School and the schools of nursing connected with St. Joseph's and St. Mary's Hospitals of Milwaukee, is being given, which means the raising of the entrance requirements in all future admissions in these schools to four years of high school.

In Washington, D. C., during the year, a central school for nurses in connection with George Washington University Medical School has grown

NURSES' HOMES OPENED DURING 1924

(Top to bottom) Eisenlohr Home of the Methodist Episcopal Hospital, Philadelphia, Pa.; nurses' home, Homeopathic Hospital, Yonkers, N. Y.; nurses' home, Hamilton General Hospital, Hamilton, Ont.; nurses' home, International and Great Northern R. R. Employees' Hospital, Palestine, Texas.

to include the eight schools of nursing of the District of Columbia and for the work of the preliminary term had in attendance 130 students. The District League of Nursing Education has been instrumental in bringing about the affiliation and has raised a fund for this central school.

This year the University of Washington, Seattle, has given, through affiliation, the preliminary course of three months to three schools of nursing in Seattle.

The Kansas State Agricultural College, Manhattan, has entered into an affiliation with the Charlotte Swift Hospital school of nursing in a five-year course leading to a degree. Real progress is reported in this school in 1924. The enrollment in the year is increasing.

In Illinois a university affiliation was planned and put into effect between the school of nursing of the Macon County Hospital, Decatur, and the James Millikin University.

Three of the schools of nursing in Arizona have arranged for certain of their classes in the University of Arizona.

Florida reports that the State College for Women has affiliated with certain schools of the state.

Kentucky reports that five schools of nursing in Louisville have affiliated with the University of Louisville and one school in Lexington has affiliated with the University of Lexington.

The University of Wisconsin has established, during the year, a school of nursing which will use for its main nursing laboratory the new Wisconsin State General Hospital. Students in this university school of nursing are not in residence at the hospital until after the end of their first semester. The first semester is spent in the College of Arts and Letters. The nursing students matriculate under the same conditions as the other students in this college.

Early in June, Washington University, St. Louis, announced the adoption of the school of nursing of Barnes Hospital. In its new relation to the university the school is under the wing of the medical college and, in addition, has a special committee composed of representatives from various faculties and interested citizens.

During the past summer the University of Colorado announced the opening of its school of nursing in connection with its plans for a new medical center in Denver.

In February of 1924 the Yale School of Nursing, admitted its first class of students. This school was founded in 1923, as an experiment in nursing education. It is financed by the Rockefeller Foundation.

The Boston University has just announced a five year liberal arts and nursing course in connection with the Boston Homeopathic Hospital school of nursing.

A slow but steady progress in public health nursing education is reported by the educational secretary of the National Organization for Public Health Nursing. Higher standards are maintained. All of the special post-graduate nursing courses in public health nursing are connected with educational institutions of collegiate grade. The certificate in public health nursing is granted for nothing less than one academic year of study in these schools. The great majority of students are high school graduates. Shorter periods of instruction, emphasizing field work, are still maintained for those nurses unable to meet fully the standard admission requirements.

In certain foreign countries there is observed the tendency to base post-graduate work in public health nursing on a board nursing education and teaching centers in public health nursing similar to those in the United States are growing up there. There is noted also a tendency to develop in public health work a type of worker apart from the nurse.

The great contributions of the American Red Cross to nursing education in this and in foreign countries have not always been realized or acknowledged. Following a brief report for the year 1924:

During the past year results of the progress in nursing education under the American Red Cross in foreign countries have been markedly apparent. In certain of them native personnel are now sufficiently trained to assume positions of responsibility and to assist in educating their own countrywomen in modern nursing methods..

In the Constantinople School of Nursing, Turkey, it has been found possible to reduce the American staff to the director and two assistants by utilizing graduates of the school as head nurses and assistant instructors; to the director and her assistant at the Warsaw School of Nursing, Poland, and the Sofia School of Nursing, Bulgaria, while at the Poznan School of Nursing, Poland, but one American nurse is now in charge.

The advance in nursing education is also extended to other foreign countries as well as to our own insular possessions. In Greece, for instance, American Red Cross nurses working with the Near East Relief have been instrumental in organizing schools of nursing in both Athens and Alexandropol. These schools, though still elementary in character, are a step toward a complete course later.

In Porto Rico the American Red Cross has been especially requested to assist with the organization of a school of nursing by furnishing properly qualified American nurses. In San Domingo, American Red Cross nurses have assisted with the organization of schools of nursing in the native hospitals and by the extension of their efforts towards instructing the people in simple nursing procedures and personal hygiene through the course in home hygiene and care of the sick. With the change of government, however, American participation in the work is ceasing. In Hayti American Red Cross nurses have continued the supervision of the school of nursing under the Haytian government. Great improvement has been seen in the character and type of student admitted and considerable development in the field open to the graduate nurse. In the Philippines the cooperation between American Red Cross nurses and the local nursing societies has

been strengthened and a League for Nursing Education has been organized which has resulted in the institution of a post-graduate public health nursing course at the University of the Philippines and improvement in the courses of instruction in the schools of nursing.

Special summer courses meaning higher education for nurses and definite instruction in teaching methods were included this past summer in the curricula in Simmons College, Boston, Pennsylvania State College and the State Agriculture College, Fort Collins, Colo., through the efforts of the American Red Cross. Designed for nurses who are, or who wish to become, home hygiene instructors, eighty-six in all availed themselves of this opportunity and many of them pay tribute to the all-around educational effect of this six weeks' post-graduate work at college. Girls, in an ever increasing number, have been encouraged to enter training schools through the taste for nursing fostered by the course in home hygiene and care of the sick.

The Army School of Nursing reports having placed its curriculum upon a unit basis and that it has strengthened its teaching and supervision, introduced better text books, enlarged its teaching laboratories and introduced the use of intelligence tests. There are 164 students in the Army School of Nursing at the present time.

Government Nursing Corps Strengthened

The strengthening of the forces of the Army Nurse Corps through post-graduate study is a most significant report for this division for the past year.

The nursing service of the United States Veterans' Bureau now requires that the graduate "follow up" nurse have had at least a four months' course in public health nursing. To improve the efficiency of the nursing service, the U. S. Veterans' Bureau Medical Council which met in Washington on November 10 and 11, 1924, recommended that a nurse corps be created in the U. S. Veterans' medical service. This has already been accomplished.

For the nursing service of our navy, growth is reported for 1924, thirty-one nurses having taken advantage of the courses offered by the bureau of medicine and surgery. Supervision provided last year through the naval appropriation act has definitely shown its benefits during the year, both in the navy nursing bureau and in the hospitals. Strengthening of the instruction given by the nurses of the navy to 4,000 hospital corps men who are to care for the navy sick in every navy vessel as well as at our naval stations is a splendid contribution.

PRESIDENT OF THE FOUR NATIONAL NURSING ORGANIZATIONS

(Left to right) Miss Adda Eldredge, American Nurses' Association; Miss Laura R. Logan, National League of Nursing Education; Miss Elizabeth G. Fox, National Organization for Public Health Nursing; Miss Jean E. Browne, Canadian Nurses' Association.

The superintendent of nurses of the United States Public Health Service reports:

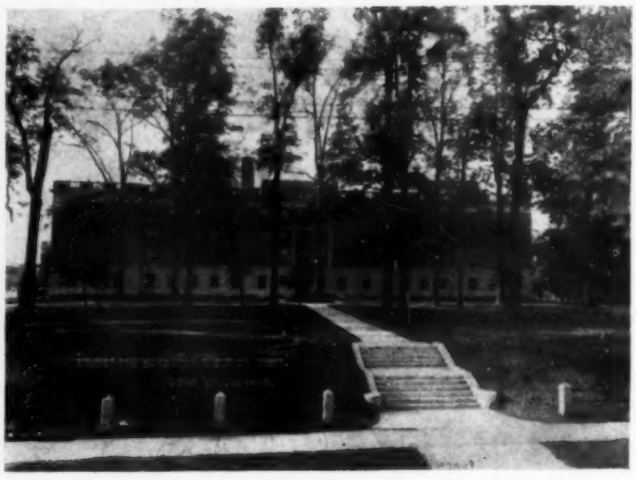
The most significant fact in connection with the U. S. Public Health Service hospitals has been the fact that during the past year the marine hospitals have been placed by the committee of the American Medical Association in the grade A group. This represents a tremendous progress in the past six years; a progress which, I believe, is due largely to the establishment of the nursing service and the placing of highly qualified nurses in these hospitals, which gave an opportunity to the officers of the service who have been anxious for the establishment of the nursing service for many years, to carry out their ideas for the increased efficiency of these hospitals.

Housing Conditions Improve

The housing conditions in schools of nursing continue to improve. There are reported for 1924 the building of new nurses' homes in several states. The type of nurses' residences built is reported to be simple and adequate from the residence standpoint with a provision for classrooms, laboratories and libraries for the school of nursing.

In the state nursing association and in their local divisions there is a marked tendency toward a more general "stocktaking" and a greater effort to meet the service which society asks of the nurse. The private duty nurse and the institutional nurse are seeing more definitely their obligations as health teachers and health promoters. The realization on the part of communities, themselves, of their obligations toward these workers and toward their preparation is, perhaps, gradually becoming more conscious.

Not only the increase in the number of well-prepared instructors in schools of nursing but the constantly increasing use of the standard curriculum prepared by the National League of Nursing Education, published in 1919, indicates a keen desire on the part of the hospital schools of nursing in each community to rise to standards of excellence in the preparation of their graduates for service to the community.



Methodist Hospital, Memphis, Tenn., opened September 1, 1924.

The outlook, therefore, for the general raising of standards of nursing education to meet community needs through a carefully prepared program of grading of schools of nursing, is promising; the National League of Nursing Education is taking definite steps to forward this grading program. The fullest cooperation is assured from each state and from the various national associations interested in the care of the sick and the prevention of disease.

LEAGUE PUBLISHES ATTRACTIVE CALENDAR

The 1925 callendar of the National League of Nursing Education, the fifth calendar published by that organization, is an attractive pictorial account of the early development of nursing education in America. Twelve representative pioneer schools are contained on the calendar. The cover embodies an artistic bit of symbolism with reference to the emergence of nursing "out of the shadows into the light."

Airplane view, new U. S. Veterans' Hospital, St. Cloud, Minn.

PROGRESS IN HOSPITAL NUTRITION DURING 1924

By RUTH WHEELER, Ph.D., and HELEN WHEELER, Iowa City, Ia.*

IN THE larger hospitals two more or less distinct lines of specialization are developing, dietary administration and dietary therapeutics. There is an increasing demand for dietitians who are chiefly administrators, trained along lines of economics and psychology, interested, skilled and experienced in personnel management and in cost distribution problems. There is an almost equal demand for therapeutic dietitians, with scientific training approaching in extent and thoroughness the work of the best medical courses; skilled and experienced in working with sick people and in adapting balanced type diets to abnormal physiological conditions of individuals and groups; cooperating with physicians in research in scientific nutrition, and giving patients the benefit of current progress in this work.

The administrator and the therapeutic dietitian cooperate to secure the best results. The administrator is finding that she must have scientific training, but she realizes that while she is dealing with a big administrative problem, she cannot also keep herself up to date as an authority in dietotherapy; the therapeutic dietitian is also something of an administrator, but she cannot undertake large problems in administration. Either may be chairman of her department but she finds that she must delegate real authority in the field not primarily hers to the vice-chairman. Lack of such delegation of authority is a weak spot in many organizations. Even small hospitals are finding that each needs an administrator and a therapeutic dietitian, working together. In larger hospitals there is an increasing tendency to have also a ward dietitian, whose chief work may be either administrative or therapeutic but who has generally some work of each kind, and is responsible for the distribution of food and for the ward kitchens; and a children's dietitian, as hospital children need very special attention.

The amount of responsibility carried by the department or by its individual members varies greatly with the ability of the individual dietitian, her especial interests, and the interests of the other people whose work touches hers. The survey made by Miss Raitt of the University of Washington, published in the November 1923, issue of THE MODERN HOSPITAL and continued by Miss Maude Perry of McGill University last year, shows great variation in hospital dietary departments.

Three types are to be found—central tray service, bedside cart service from distributing kitchens situated near the wards. Strong arguments in favor of each are heard. Central tray service, however, tends to machine feeding, with too little adaptation to individual needs, though it need not do so; in some hospitals it cuts the nurse completely out of the food service, sending out newly graduated nurses without practical experience in nutrition. Bedside cart service is found to be useful in some hospitals in lessening waste, because with this kind of service the patient is less often served food that he will not eat; it can be made a very valuable means of teaching student nurses how to adapt general diets to special cases, and the food is more likely to be hot when the patient gets it. An objection to this type of service is the probability that the patient will be served with what he wants rather than with what he needs. Tray service from distributing kitchens adjacent to the wards may combine the advantages of the other two types; student nurses can serve their own patients and can have practice in adapting general diets to individual cases; patients can be served according to their special needs.

Most superintendents now welcome real cooperation and initiative from their dietary departments, and in some of their hospitals studies of

Dietetic Specialization

DIETETIC expansion during 1924 has been marked by development of two distinct lines of specialization, dietary administration and dietary therapeutics. This development is witnessed in small as well as in larger hospitals where specific problems demand specialists in dietetics. Teaching work among medical students and nurses has advanced in many medical centers and hospitals. Courses of training for dietitians are not yet standardized, but the demand for more training, extensive and intensive, is becoming apparent. One state university hospital is now accepting interns in nutrition on the same basis as interns in medicine or surgery.

*Dr. Ruth Wheeler holds the chair of professor of nutrition in the college of medicine, State University of Iowa, and is this year president of the American Dietetic Association.

systems and methods of buying are in progress. In Massachusetts General, in Peter Bent Brigham and in the Children's Hospital—all of Boston, in the nurses' home of the Presbyterian Hospital, Chicago, and elsewhere, food cost distribution is being constantly studied; cost distribution through the year and among different classes of foods is also being studied, and this is being better correlated with nutritive value.

Attention Centers on Specific Problems

From the nutritive aspect, dietary departments are taking more responsibility in the study of their specific problems, both in cooperation with medical specialists and among themselves. In many institutions the general diets for ward patients have been greatly improved during the last year, the economic aspect being no longer considered by itself, but in conjunction with the nutritive needs of the patient. In many cases the old allowance per capita of so many ounces of milk or butter or meat has been discovered to be less than known nutritive requirements and has had to be increased. If the per capita cost allowance has been found insufficient to allow adequate feeding, this has been increased. A few institutions still feed butter substitutes to sick people, and even to children; a few still serve so little milk and so few fresh fruits and vegetables that the patients' resistance to infection is lower than it needs to be; and in the case of children, growth is interrupted while they are in the hospital and in need of the very best conditions possible. To serve diets which are nutritively adequate and still to reduce the total costs of the food is the object of much serious study among dietitians. The constant reduction of waste and the substitution of cheaper foods when the nutritive value is not thereby impaired is a study in itself.

Patients Are Taught Food Values

Patients are being taught food values and their food needs instead of the earlier catering to whims. In consequence they are leaving the hospital better equipped to maintain health, and they appreciate this fact. At Saint Mary's Hospital, Rochester, Minn., classes in nutrition are held twice a week for patients, and the dietitian can invite any patient able to attend. In many hospitals the bedside teaching long given to diabetics is being extended to other patients. In Saint Mary's Hospital and elsewhere student nurses are given bedside teaching in nutrition, and the school of nursing at Yale University has a special dietitian to do just this sort of teaching. The general tendency is to give student nurses more and better training in scientific feeding, but some hospitals, like the Fifth Avenue Hospital in New York City, consider that efficiency is maintained by having as few people as possible concerned in their nutrition problems. In these hospitals the dietary department and its employees constitute the whole feeding machine.

Doctors and Nurses Need to be Taught

All over the country, doctors as well as medical students are asking for more information, both theoretical and practical, about food. In Seattle a group in private practice has formed a class which meets with a dietitian in the home economics department of the University of Washington for lectures on dietotherapy. Many dietitians in hospitals and outside them are receiving requests for similar lectures. University hospitals in New York, Ann Arbor, Iowa City and elsewhere have instituted courses of lectures in dietotherapy for medical students; in the State University of Iowa, these are a part of the course in therapeutics.

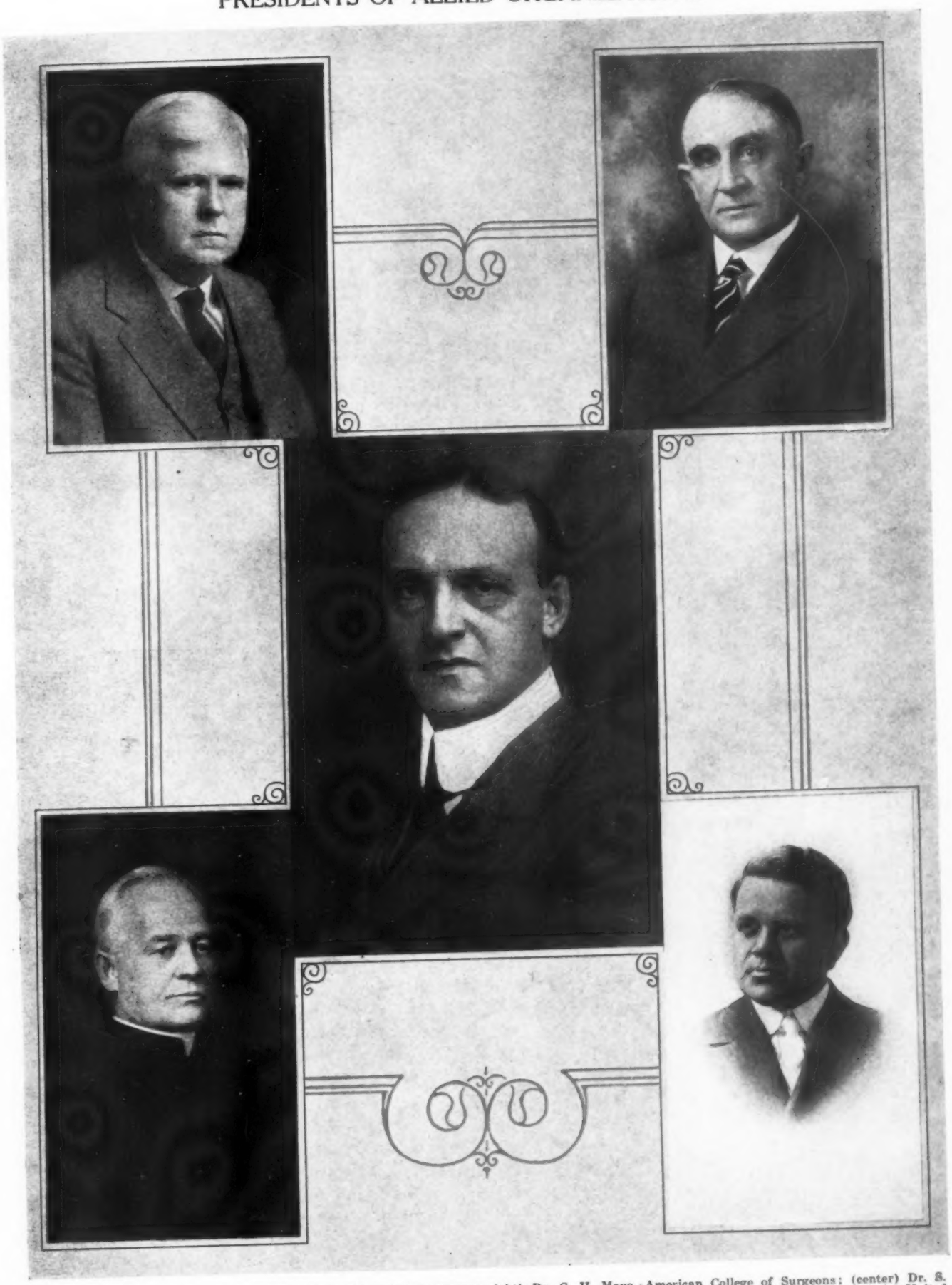
Courses of training for dietitians are still far from standardized—which is perhaps just as well, since the profession and the title are still so vague and indefinite—but in the light of the developments just noted it is likely that the apparent tendency towards more training, both extensive and intensive, is real. Two-year courses in home economics are not sufficient foundation for hospital work, and prospective dietitians have come this year chiefly from recognized colleges and universities. The three-months' course of training is giving way to one of six months or a year, in order to include more experience involving real responsibility and authority in a known environment and definite studies of the various types of problems involved in the work.

Dietetic Interns in University Hospitals

In the State University Hospital at Iowa City, only women of at least a year's practical experience are accepted for training. They become interns in nutrition on the same basis as interns in medicine or surgery. Here, as in other university hospitals, hospital dietitians of successful experience have an opportunity to bring their knowledge of scientific nutrition up to date and to work at specific problems under the auspices of the graduate college. Everywhere prospective dietitians are being brought closer to the kitchens, the patients, and the research laboratory.

All of this means very rapid progress during the last ten years, progress which is typified in the growth of the American Dietetic Association, founded in 1917 with 30 members, and having now, seven years later, nearly 800 members in good standing.

PRESIDENTS OF ALLIED ORGANIZATIONS



(Upper left) Mr. E. S. Gilmore, American Hospital Association; (upper right) Dr. C. H. Mayo, American College of Surgeons; (center) Dr. S. S. Goldwater, American Conference on Hospital Service; (lower left) The Rev. C. B. Moulinier, Catholic Hospital Association of the United States and Canada; (lower right) The Rev. N. E. Davis, Protestant Hospital Association.

DISPENSARY PROGRESS IN 1924

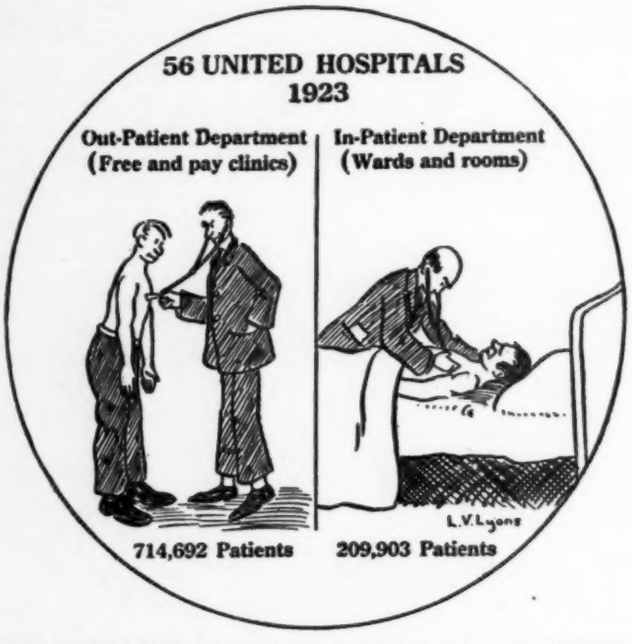
By MICHAEL M. DAVIS, Jr., Executive Secretary, Committee on Dispensary Development of the United Hospital Fund, New York, N. Y.

THE growing recognition of the out-patient department both in the treatment of disease and its educational factor is well expressed in an address* delivered during the past year by Doctor David L. Edsall, dean of the Harvard Medical School, in which he said:

"The undefined and the mild conditions, early chronic diseases, and the like, will constitute the practitioner's chief work always, and especially in his early practice. They are the most difficult of all to achieve real skill in. It is proper that he should approach them with previously gained confidence and power through study of the things that are more demonstrable and more definable, but I do not think that he now gets as much training in the milder things as he should have, either in his course in medicine or in the usual hospital internship.

The most obvious and the most effective way of doing this is through greater use of the out-patient department by both students and interns. There the conditions under discussion are found in numbers. To make this successful, however, out-patient departments must be given a different status.

"To be well done, and particularly for teaching to be well done, there, the senior men must, to some extent, go back into the out-patient department and take some active part in it and its guidance. It is equally important that out-patient departments be so managed that the work is not the mere routine of handling the sick. Opportunities must be developed for careful and contributory study of disease there. Not only will this aid in the improvement of the young practitioners, it will also aid greatly in very desirable studies of early disease, and in real service to the patients. One of the first necessities, I believe, if this is to be done successfully, is to restrict the number of patients seen in the out-patient department to the number that can be carefully studied by the staff available, just as is done in the wards."



The up-to-date hospital cares for the vertical as well as the horizontal patient. (From the 1924 report of the United Hospital Fund of New York, N. Y.)

The movement for the framing of standards of out-patient service pursued by the American Hospital Association through its committee on out-patient work made some progress during the past year, such standards being printed and circulated for criticism by the committee and discussed at the Buffalo convention. Pursuant to a resolution then passed, it is anticipated that after further revision, standards of out-patient service will be reported to the association next year for official consideration and adoption.

One of the ways in which the overcrowding, long waiting and other inefficiencies of the old-fashioned dispensary may be diminished and the work required of the doctor be better proportioned to the time available, as Doctor Edsall suggests, is through the admission of patients by appointment. The Children's Hospital in Boston and the Nursery and Child's Hospital of New York have, since last year's report in THE MODERN HOSPITAL, developed appointment systems. The report from the Presbyterian Hospital, New York, published in the January, 1924 issue of this magazine, page 92, indicates its successful working there.

Inquiry into this subject during the year has emphasized the point that an "appointment system" does not imply a certain rigid scheme whereby each patient is told to come at a certain day and hour. An appointment system may be merely by the day, or by a clinic session, or it may be by day, hour, and minute; it may be for a single clinic or department of a large dispensary, or it may be for the entire institution. Some institutions, for example, find their patients overcrowding them on the first days of the week, with relatively slim attendance on Thursdays and Fridays. A simple system of assigning by days appointments for revisits will distribute this load, and may be applied to all departments or only to those departments where the pressure is most felt. Such schemes are not infrequently found in operation.

An institution should therefore consider how far it needs to go in developing an appointment system to meet its own peculiar problems. Reports from many institutions also indicate that the chief problem in the appointment system is not the patient but the doctor. Patients are more apt to come on the day and hour requested, than do the practitioners who give only a fraction of their time to the out-patient work.

*Address delivered before the section of medicine at the annual meeting of the Massachusetts Medical Society.

It is also an essential condition of any successful appointment system that the clinic doctor accept the responsibility of deciding, each time he sees a patient, whether that patient needs to return for treatment, if so, when; if not, a discharge note should be entered on the record. It is obvious that any clinic which has a "follow-up system" can, by a very slight development, have an appointment system. (See THE MODERN HOSPITAL for July, 1924—"What Do We Mean by a Follow-up System?" by Ethel C. Taylor).

Extensive Report on Record Forms

The dry, but always important, subject of record forms received enlargement during the year through the extensive report of a committee of the Associated Out-Patient Clinics of New York City headed by Doctor E. M. Bluestone. A full set of out-patient forms with explanations of their use was developed as the result of many months of work and is available to the hospital world through its publication in the August, September, and October numbers of the magazine.

Courses in Clinic Management

The training of persons for the management of out-patient clinics received an impetus during the year through courses on management of clinics and health centers offered in the summer institutes of the United States Public Health Service. These were held in cooperation with several important universities such as Columbia, Michigan, Iowa, and California. An analysis of the attendance at the courses offered at two of the larger centers showed that public health nurses associated with health departments and with voluntary health organizations are increasingly required to take charge of clinics of various types. Nurses of this group constituted about two-thirds of the attendance.

Interest appeared to center in clinics for babies and children, school clinics, tuberculosis clinics, and venereal disease clinics. The administrators and other personnel of the out-patient departments of hospitals were hardly represented among the students in these summer courses. Health departments and voluntary health organizations, on the other hand, have evidently been brought by the advance of preventive medicine to enter the clinic field, and consequently to seek training for their personnel.

Health Demonstration Clinics

For the same reasons the development and coordination of clinics is playing a notable part in the problems faced by numerous "demonstrations" conducted by large national organizations, such as the child health demonstration at Mansfield, Ohio, and the health and tuberculosis demonstrations of the Milbank Memorial Fund in New York state.

Out-patient Service on Self-supporting Basis

Two notable experiments in putting out-patient service on a self-supporting basis have come further to public attention during the past year. The pay clinic conducted by Cornell University Medical College in New York City has issued its second annual report, indicating that the point of self-support has been reached. With an admission fee of $1.50 and special fees for medicines, x-rays, laboratory tests, etc., the average income is about $2.25 per visit.

Criticism by the local medical society during 1924 drew national attention to the Henry Ford Hospital in Detroit, Mich. Until this year the scope of the out-patient service of this institution has probably not been appreciated. With an average daily attendance nearing four hundred persons, the service to ambulatory patients exceeds the number of individuals cared for in the bed service of the hospital. It is really a great pay clinic about the same size as the Cornell Pay Clinic. In some quarters the impression has been gathered that the Ford clinic is for diagnosis only. Diagnosis is indeed one of its important functions, but a very large amount of the service rendered to ambulatory patients is in treatment as well as diagnosis. The medical and administrative methods pursued at the Ford Clinic are worthy of careful study by all interested in out-patient service.

A. M. A. Lists 3,294 Dispensaries in 1922

During the year the United States Census Bureau issued a report on the number of hospitals and dispensaries in the United States. The figures, as given, were stated to be "preliminary and subject to correction," but it may be a matter of surprise that the total number of dispensaries was given as only 2,313, for the year 1922. The American Medical Association had previously published figures for the same year showing 3,294 dispensaries on its lists, with enough additional institutions estimated to exist to bring the total to 4,000. It may be hoped that the final reports of the Census Bureau will be more complete.

A further article in THE MODERN HOSPITAL will contain summaries of reports received from the annual dispensary questionnaire which has been answered by a larger number of institutions than in any preceding year.

PRESIDENTS OF STATE AND SECTIONAL HOSPITAL ASSOCIATIONS

(1) Dr. Charles N. Combs, Indiana; (2) Mr. George S. Hoff, State of Illinois; (3) Dr. T. H. Gruber, Michigan; (4) Mr. B. W. Stewart, Ohio; (5) Dr. B. S. Pollak, New Jersey; (6) Mr. W. W. Rawson, Utah; (7) Dr. L. D. Johnson, Kansas; (8) Dr. R. W. Corwin, Colorado; (9) The Rev. H. L. Fritschel, Tri-State and Wisconsin; (10) Dr. K. H. Van Norman, Minnesota; (11) Dr. Joseph C. Doane, Pennsylvania; (12) Dr. J. C. Stubbs, Illinois; (13) Dr. Rush E. Castelaw, Missouri; (14) Mr. Charles Lee, Connecticut; (15) Dr. C. M. Strong, North Carolina; (16) Dr. George H. Stone, New England; (17) Dr. Fred S. Clinton, Oklahoma.

THE DEVELOPMENT OF HOSPITAL HOUSEKEEPING

By C. W. MUNGER, M.D., Director, Grasslands Hospital, Valhalla, N. Y.

LITTLE record has been preserved of the methods of housekeeping employed in the earliest hospitals. Descriptive material is available concerning some of the very old hospitals of England, and in them one finds occasional mention of an existing state of cleanliness or uncleanliness of the buildings. One rather humorous account of conditions in England tells how perfume was used in an attempt to mask odors and how the attending physician customarily held his handkerchief to his nose while making rounds. Practically nothing is said, however, concerning actual housekeeping methods, good or bad.

Hospital housekeeping must needs have been evolved from the housekeeping methods employed in the home. In fact, the precursor of even the most primitive hospital must have been the sickroom in the home. Then followed hospitals which were comparable to the small nursing homes. It is safe to assume that the cleaning and other housekeeping procedures in these nursing homes differed only in a slight degree from those practiced by every conscientious and efficient housewife.

Before the days of Lister disinfection and asepsis were essentially unknown. Housekeeping methods had as their principal aims the production of an appearance of cleanliness and the eradication of unpleasant odors. There was probably little concern as to whether the floor was bare or carpeted and as to whether or not cleaning operations produced dust. Early housekeepers for the sick, however, had the same incentive as we now have for doing their work quietly.

Changes of the Antiseptic Period

The first marked changes in housekeeping methods came with the advent of the "antiseptic," followed soon after by the "aseptic" period. In the earlier days of bacteriology dust was considered even more than nowadays a very dangerous factor in hospitals. Bare floors—wood, followed later by cement, tile, and terrazzo became customary. Wet cleaning was the rule with these floors. Sweeping, if done at all, was accompanied by the use of some oily compound which prevented dust. The impervious flooring materials which developed were desirable from the point of view of cleanliness, but were hard, cold, and very noisy. These facts encouraged experimentation with impervious floorings of softer material, and thus there have developed such floor "coverings" as linoleum, hard rubber, and the various compositions.

A housekeeping operation which had previously been used occasionally on wooden floors came into common use in connection with linoleum, namely, the waxing process. This involved application to the linoleum of a thin coating of wax in liquid or paste form, followed by thorough polishing. This produced a practically non-absorbent surface to which very little dirt could adhere. Frequent scrubbing was not necessary and dust-absorbing compounds were used in connection with the sweeping.

The more recent rubberized floorings require no waxing but, where traffic is heavy, require frequent wet cleaning.

From Antisepsis to Asepsis

In the earlier days of bacteriology, disinfection following communicable diseases had a very great vogue. Gases, such as sulphur dioxide and formaldehyde, were generated in tightly sealed rooms and were thought to kill all bacteria. Later research has proved these methods inefficient.

Evolutionary Steps in Hospital Housekeeping

HOSPITAL housekeeping must have been evolved from the housekeeping methods employed in the home. In fact, the precursor of even the most primitive hospital must have been the sickroom in the home."

"The first marked changes in housekeeping methods came with the advent of the 'antiseptic,' followed soon after by the 'aseptic' period."

"Mechanical and labor-saving devices, in general, have made a valuable contribution to the housekeepers' efficiency within the past twenty years."

"There is still room for much improvement in the care of buildings and equipment as practiced in the average institution. The evolution of hospital housekeeping has been by no means as rapid and as laudable as the progress made in the surgical and nursing fields."

They have been largely displaced by the use of soap and water or other mild disinfectants in actual washing processes of room and contents. The evolution from antisepsis to asepsis or from disinfection to sterilization, while it had a profound bearing upon nursing procedures, did not greatly affect housekeeping methods.

The changes in methods of laundering linen have been somewhat analogous to those of general cleaning. Early methods required that linen be free of visible dirt. Modern methods require this and also that the linen be freed of pathogenic bacteria, as well. There was little change from the method used at the family washtub until, with the advent of steam, mechanical washers and extractors came into vogue. Steam was also employed as a means of heating water and of actually sterilizing linen. Laundering was again made easier and more efficient by the development of the electric motor for the operation of washers, extractors, mangles, and drying fans. The electric iron has simplified hand ironing.

Contribution of Labor-Saving Devices

Mechanical and labor-saving devices, in general, have made a valuable contribution to the housekeeper's efficiency within the past twenty years. Mechanical scrubbing machines enable one man to clean floors which formerly would have required the work of several. Most of the scrubbing machines may also be used as polishers of waxed floors.

The vacuum cleaner has made it possible for hospitals again to use rugs as floor covering and to use heavier and more decorative hangings for windows. The modern hospital of today need be troubled very little from dust in connection with cleaning operations.

In spite of the marked progress outlined, there is still room for much improvement in the care of buildings and equipment as practiced in the average institution. The evolution of hospital housekeeping has been by no means as rapid and as laudable as the progress made in the surgical and nursing fields. Hospitals should pay still more attention to housekeeping, particularly in the systematization of methods. They will thereby improve the efficiency of this neglected phase of hospital work and will bring about important economies.

VETERANS' BUREAU FORMS ADVISORY COMMITTEE OF NURSES

The director of the U. S. Veterans' Bureau has approved the recommendation of the medical director to establish an advisory committee of nurses to act in the capacity of advisors to the medical director and the medical council. Eight nurses, national leaders in nursing, social service, and public health nursing have been designated members of this committee.

The function of this committee is to advise the medical director, the medical council, and its committees, on the above mentioned subjects, with the object of improving the nursing service to our disabled veterans. The following nurses have been invited to serve on this committee: Miss Adda Eldredge, president, American Nurses Association; Miss Laura R. Logan, president, National League of Nursing Education; Miss Clara D. Noyes, director, nursing service, American Red Cross; Major Julia C. Stimson, superintendent, Army Nurse Corps, and dean of Army School of Nursing; Miss Elizabeth Fox, president, National Organization of Public Health Nursing; Miss Lucy Minnigerode, superintendent of nurses, U. S. Public Health Service; Miss J. Beatrice Bowman, superintendent, Navy Nurse Corps; and Miss Harriet Bailey, educational director, Bellevue and Allied Hospitals, New York, N. Y.

It is felt that the interest and cooperation of these leaders in the nursing profession will be of inestimable value and assistance to the nursing service of the bureau by interpreting to the public what the Veterans' Bureau is doing for the care of the ex-service men.

The advisory nursing committee will meet in Washington, D. C., at the time of the next meeting of the medical council which is composed of eminent specialists in the medical profession throughout the United States, who meet in Washington, D. C., from time to time, to advise the director of the U. S. Veterans' Bureau on vital medical problems.

The following dispensary licenses have recently been issued by the state of New York: Lebanon Hospital Dispensary No. 2, Bronx; Judson Dental Clinic No. 3, Manhattan; Brooklyn Health Examination Dispensary 69, Brooklyn; Field Center of the Maternity Center Association, Inc., Brooklyn; United Hospital Dispensary, Port Chester; Steuben Street Dental Clinic, Brooklyn; Hudson Guild Dispensary, New York.

U. S. Veterans' Hospital No. 96, Tupper Lake, N. Y.

ACTIVITIES OF THE AMERICAN ASSOCIATION OF HOSPITAL SOCIAL WORKERS DURING 1924

By LENA R. WATERS, Executive Secretary, American Association of Hospital Social Workers, Chicago, Ill.

THE purpose of the American Association of Hospital Social Workers, as set forth at the time of its organization in 1918, is as follows: "To serve as an organ of intercommunication among hospital social workers, to maintain and improve standards of social work in hospitals and dispensaries, and to stimulate its intensive and extensive development." This is an ambitious purpose, requiring a many-sided program.

Membership in the association falls into three groups: (1) active members—those who are professionally engaged in the practice of social work in hospitals and dispensaries; (2) associate members—those formerly active members, but not now engaged in active work; and those whose work is closely allied to hospital social work; (3) corporate members—institutions and organizations maintaining social work in hospitals and dispensaries.

The association has grown from a small group of people who met each other at the time of the annual meetings of the National Conference of Social Work and who discussed in an unplanned way their mutual problems and methods, into a definitely organized group of the social workers in the hospitals and dispensaries of the United States and Canada. It has outgrown the offices so generously donated for two years by the Johns Hopkins Hospital, Baltimore, and has become established in its own headquarters at 30 East Ontario Street, Chicago.

Membership Now Over 1,200

In 1918 there was a membership of fifty. 1924 shows a membership of over 1,200. A very large majority of those eligible for active membership have enrolled, and there is a steady increase in the number of associate and corporate memberships, showing a gratifying confidence on the part of those interested in the support and further development of this new hospital service. The United States Census Bureau reports 574 hospital social service departments.

Two Districts Added During Year

For the purpose of providing opportunities for more intensive work, for the development of local initiative and self-expression, and for a more general interest in hospital social service, the plan of decentralization was adopted, and where there is sufficient local strength subdivisions or districts are organized. There are now ten districts in the organization, as two new ones were added during the past year. The Eastern Central District covers parts of Ohio, West Virginia, Pennsylvania and New York, and the Eastern Canada District includes the workers of the cities of Toronto and Montreal.

Hospital social service has certain definite functions:

(1) Service to the patient as a part of hospital therapy.
(2) It serves as the connecting link between the hospital and the community in the treatment of the individual patient and the general health program of the community.
(3) It serves to create better understanding through interpretation of the hospital to the community and the community to the hospital, strengthening the work of both by bringing about better results.
(4) It serves to assist in research by studying groups of cases and helping to remove causes of disease, and increasing facilities for complete treatment when the need is indicated by such study.
(5) It makes a definite contribution to the education of medical students.
(6) It makes a definite contribution to the education of student nurses.
(7) It makes a definite contribution to the education of general social workers.

Progress in Social Work

PROGRESS in the development of hospital social work can best be measured by the accomplishments of the American Association of Hospital Social Workers. During the past year this body has added two new districts to the organization, bringing the total up to ten. In its round tables in district programs and in those with allied organizations it has stressed the responsibility of hospital social work to the community.

The various sections and special committees have given detailed study to the individual problems assigned to them. Of special interest is the problem of the committee on training which is working out a plan to provide more and better trained hospital social workers.

(8) It makes a definite contribution to the special training and education of medical social workers.

With these functions in mind the programs for the activities of the districts and the section on psychiatric social work, and the committee studies are planned.

There has been more active participation during the past year by members of the association than in any year previously, 350 members giving service on various committees. In addition to a few general public meetings each year, each district plans a series of continuous round tables or small group studies for those who are interested in some specialized topic. A review of the past year's district programs is of interest because it shows common ideals as well as problems peculiar to each district.

Hospital Social Work in the Community

The responsibility of hospital social work to the community has been brought out in almost every district program, the titles of such discussion varying, from, "As Others See Us," in Michigan, to "The Relationship of Hospital Social Service to the General Plan of Community Activity," in Illinois. The desirability of some provision for case discussion as part of the district program was expressed by several districts. New England is discussing "Ethics," in one of its round tables. Three districts discussed social treatment for the crippled, bringing out the great opportunity to help the permanently handicapped in adjusting their mental attitude and in making possible vocational training.

The result of the discussion of this topic in St. Louis was the appointment of a committee, representing the interested agencies of the community, to make a survey of resources for the treatment of the handicapped in St. Louis, with the idea of using this committee report as an argument for the establishment of a permanent bureau for the handicapped. Venereal disease, psychiatric problems, tuberculosis, cardiac, diabetes, were discussed by practically all districts either through round tables or in general meetings. Two districts report sections for executives. These sections are discussing questions such as "Making Social Work a Profession," "Its Demands," "The Necessity of Research," "Should the Admission Clerk be a Social Worker Under the Administration of Social Service Department," "Records," "Training of Students and Apprentice Workers," "Further Education of Staff Personnel," "Boards and Advisory Committees," "Development Plans for Progress of a Department."

The section on psychiatric social work reports as accomplishments: (1) publicity work—reprinting article for distribution to colleges; (2) preparation of bibliography; (3) a special association bulletin; (4) reading list on mental hygiene prepared by section's executive committee; (5) beginning of a permanent exhibit; (6) work on dictionary terms.

The section emphasized the continuation of the present form of organization, need for constant recognition of qualified social workers, and discrimination between them and other workers in mental hygiene without social training, disuse of term "psychiatric worker" and psychiatric section" meaning "psychiatric social worker" and "section on psychiatric social work," help in maintaining and improving standards of training, and continued publication of literature for general distribution.

The committees during the year concerned themselves with such studies as membership qualifications. Two issues were discussed on this question: (1) Shall we base active membership on training and experience? (2) What should be the difference between active and associate membership? There has been a strong feeling among some of the members that the voting power should be confined to active members of the association, who should, in all cases, be professional social workers. There is a growing feeling that associate members should be given a voice in the affairs of the association; that on questions of technique, and similar professional matters, the professional workers should have full responsibility, but that in the determination of its broader more general policies as a country-wide organization, the associate members should be given a vote. It is felt that through such recognition there will be greater interest from the associate members, and the association will be richer in both its financial and educational programs.

Hospital Social Service Training

With the rapid growth of social service departments and the increasing demand for social workers, especially trained for this branch of work, the committee on training is working on a plan to provide more and better trained hospital social workers. They are endeavoring to standardize the training for this special field, to recruit students, and to raise a fund for scholarships. During the past year this committee has been called in to advise on the development of training courses in two state universities. A six weeks' institute for hospital social workers was offered by the school of social workers at Simmons College. Summer courses were offered at several other established schools.

The committee on functions is endeavoring,

through study and evaluation of present practices and results, to define the field of hospital social workers.

Study Made of Record Forms

The committee on records made a comprehensive study of the record forms used in various social service departments, and submitted a report at the annual meeting in Toronto. The committee conducted its studies through cooperating sub-committees appointed in each district, thus bringing into the study groups representing every section of the country and in this way creating a more thoughtful attitude and a feeling of greater responsibility towards records.

During the past year hospital social work has been represented through exhibits at the annual meetings of the American Hospital Association, the American Medical Association, the National Conference of Social Work, and at numerous state and local organization conferences. This has been the responsibility of the exhibit committee.

The committee on publications is responsible for a series of leaflets for general distribution to those interested in the development of hospital social work. It will also be responsible for the selection and placement for publication of articles on hospital social work, and for continued work on the bibliography.

Interest of Allied Groups Considered

During the year the committees for the programs for the annual and semi-annual meeting have kept in mind the interests of the allied groups with whom the association meets, as well as the group of hospital social workers, and have arranged interesting programs which have included talks on "The Philosophy of Social Work," "Convalescence," "Social Treatment of Cardiacs," "Books for Social Workers," "Need of Psychiatric Social Work in a General Hospital," "The Application of Social Service in the Small Hospital," "The Physician and the Medical Social Worker," "The Use of Recreation as a Method of Social Treatment," and similar subjects.

The association maintains an information service and during the year has responded to thousands of requests for information on questions of especial interest to hospital social workers, hospital superintendents, social service committees and interested social organizations.

A bibliography has been published by the association through the work of a special committee. This bibliography includes 492 articles and books on hospital social service.

Six Bulletins Issued During Year

Six bulletins were issued during the year to members of the association. These bulletins covered reviews of the meetings of the association; a review of the report of the American Hospital Association's survey on "Training for Hospital Social Work"; an article on the salaries paid to hospital social workers; an article on training courses for student nurses; and other topics of special interest to the group.

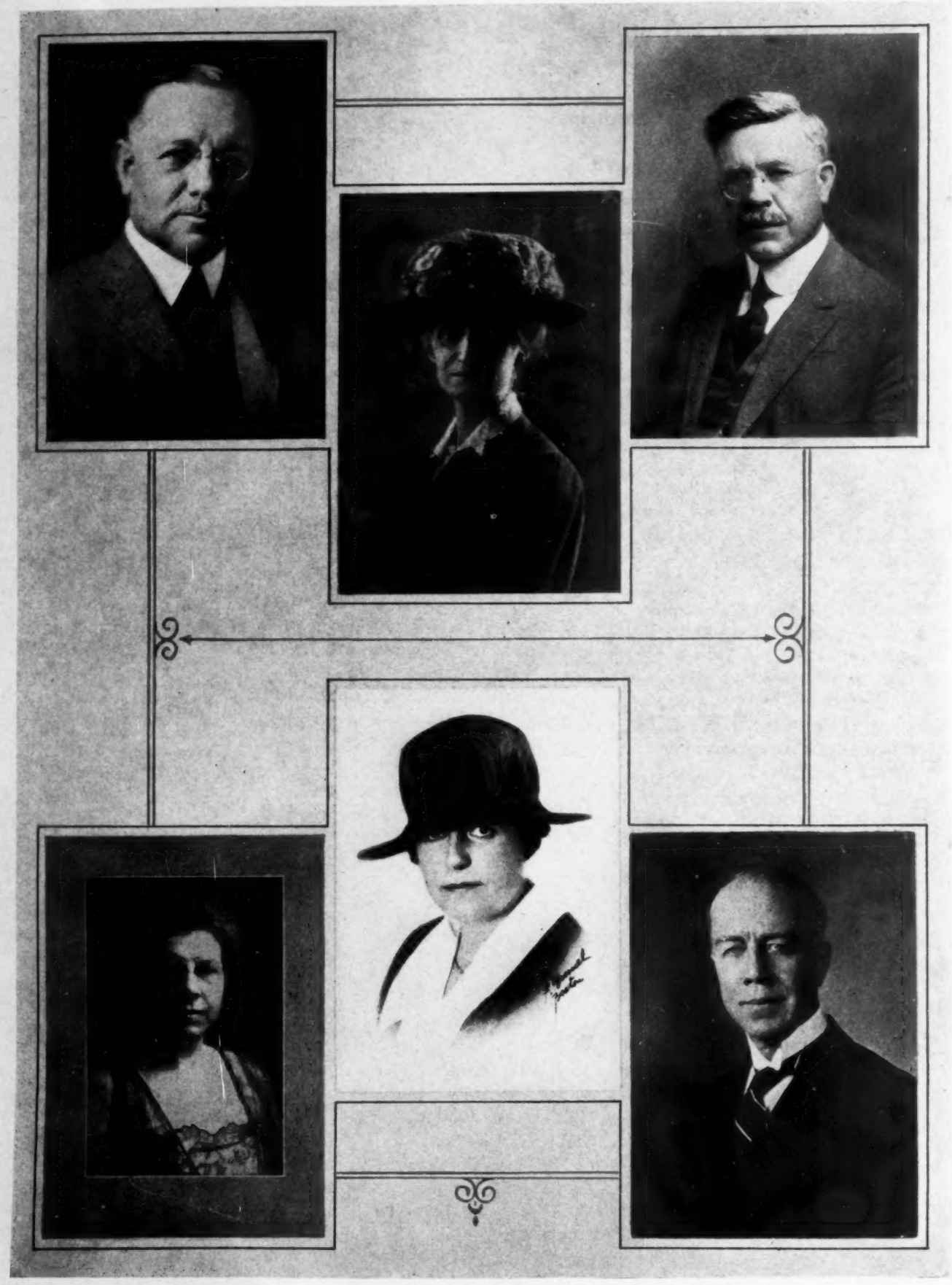
Field service for the purpose of survey of hospitals desiring to introduce social service, or of existing social service departments is provided upon request; also field service for purposes of consultation and of divisional organization matters is one of the planned activities of the association.

Hospital social work has been represented on the program and in the conferences of many of the other national organizations in the health and social work field.

Throughout the year the keynote has been higher standards, better training in order that there may be more efficient service, closer relationship with other hospital service, and a clearer understanding and more active cooperation with social agencies of the community.

Children's Hospital, Tulare-Kings County Tuberculosis Sanatorium, Springfield, Cal.

PROMINENT FIGURES IN THE HOSPITAL FIELD



(Upper left) Dr. Charles Emerson, president, National Committee for Mental Hygiene; (upper center) Dr. Ruth Wheeler, president, American Dietetic Association; (upper right) Dr. F. M. Pottenger, president, American Sanatorium Association; (lower left) Miss Rena Eckman, president, Hospital Dietetic Council; (lower center) Miss Mabel Wilson, president, American Association of Hospital Social Workers; (lower right) Mr. T. B. Kidner, president, American Occupational Therapy Association.

RECENT DEVELOPMENTS IN CONTAGIOUS DISEASE CONTROL OF INTEREST TO HOSPITALS

By D. L. RICHARDSON, M.D., Superintendent, Providence City Hospital, Providence, R. I.

DURING the last two or three years epochal work has been done on scarlet fever. Dr. George F. Dick and his wife, Dr. Gladys H. Dick, working in the laboratories of the John McCormick Institute in Chicago in 1923 claimed to have successfully inoculated two human beings with a hemolytic streptococcus obtained from an infected finger of a nurse who was suffering from mild scarlet fever. This infection began two days before the onset of the disease. Since that time they have successfully inoculated other human volunteers.

Next an attempt was made to find some way of differentiating the scarlet fever hemolytic streptococcus from other streptococci. It was found that of hemolytic streptococci cultures taken from one hundred scarlet fever patients, 16 per cent did and 84 per cent did not ferment mannite. Scarlet fever was produced in human beings by both strains. Attempts to isolate this organism by agglutination methods employing the blood serum of persons who have had clinical scarlet fever failed. While no method of detecting the scarlet fever strain of hemolytic streptococci has yet been devised, the experimental inoculations indicate that the disease is caused by an hemolytic streptococcus.

Infections Due to Streptococci

There is much clinical evidence to support their claim. It is well recognized that most, if not all, local infections occurring during the course of the disease are due to streptococci. But while streptococci may cause secondary infections during the course of other infectious diseases, such cases are far less frequent. There is another very suggestive occurrence which has been noted in scarlet fever outbreaks in hospitals, particularly in lying-in institutions. Few of these have been reported but some are known to the writer. In these outbreaks of scarlet fever there have also occurred cases of erysipelas and acute lethal infections, including fulminating peritonitis, which have been clinically ascribed to a streptococcus infection.

In this connection it is worthy of note that over half of all investigators who have claimed to have discovered the cause of scarlet fever, have ascribed it to streptococcus. This clinical experience impresses competent observers that Dr. and Mrs. Dick have discovered the cause of scarlet fever.

Out of this discovery have come some other developments which are of great interest to hospitals and other institutions. There has been prepared by Dochez and Dr. and Mrs. Dick, an antitoxin for scarlet fever by inoculating horses with the scarlet fever streptococcus, either using toxin as is done in the preparation of diphtheria antitoxin, or by employing living cultures. Up to date the use of this serum in several hospitals cannot be said to have been generally successful. Reports of different observers are confusing. Since up to date there has been no reliable method of determining the strength of the streptococcus toxin the lack of this knowledge is a great handicap in the preparation of a serum. It is quite possible that by improved methods a serum of real value may be brought out. At the present time scarlet fever antitoxin is on the market and is worth a trial, if bought from concerns whose products are vouched for by the United States Public Health Service.

Another discovery of much importance is that persons who have had scarlet fever show a negative skin reaction when small amounts of toxin

Immunizing Methods

"OUT of the discovery of the cause of scarlet fever have come some interesting developments. . . . There has been prepared an antitoxin for scarlet fever by inoculating horses with the scarlet fever streptococcus or its toxin. . . ."

"Immunization against diphtheria is being put into general practice throughout the country. . . ."

"It is of great interest to hospitals and especially to infant asylums to know that it is possible to immunize children against measles after the children have been exposed to this disease."

"Hospital interest in the matter of immunizing should be greater than it is. As a general public health measure a hospital might well test all patients and immunize the susceptibles."

are injected intradermally. On testing children at different ages and also adults, it has been found that the positive reactions (persons susceptible to scarlet fever) follow very closely the percentage of positive reactions found when testing for diphtheria susceptibility with diphtheria toxin.

The test consists of the intracutaneous injection of from 0.1—0.2 cc of a soluble toxic filtrate obtained from the culture of scarlet fever hemolytic streptococcus. The positive reactions resemble closely the results of the schick tests except that the reaction comes earlier, does not last so long and is rather less pronounced.

Experiments with the Dick Test

Of special interest is a report by the Dicks of the testing of 125, and immunization of fifty-two persons who had been exposed to scarlet fever, including nurses and patients in a contagious hospital. All persons who showed positive skin tests were treated with three doses of scarlet fever toxin, provided they did not have a sore throat. Five of the number had sore throats and were passively immunized with convalescent scarlet fever serum. None of these 125 persons contracted scarlet fever. Thirty-two nurses and interns on whom skin tests were not made, and two nurses with positive skin tests who had not completed immunization treatment, acted as controls. These two nurses and five of the thirty-two nurses and doctors contracted scarlet fever.

These results, of course, should be confirmed, but the work was carefully done and merits the confidence that immunization against scarlet fever may be possible.

If these discoveries are confirmed and perfected, a great advance in the methods of the control of scarlet fever will have been gained and they will be put upon a much more scientific basis.

Diphtheria Immunization

Immunization against diphtheria is being put into general practice throughout the country. It was first discovered and tested out in the laboratories of the health department of New York City about ten years ago. It was reported in the last bulletin of the department that over 500,000 school children have been Schick tested and, when susceptible, have been immunized. About four or five thousand immunized persons have been kept under observation during a period of eight to ten years and they have continued to be immune to diphtheria except in a few instances. This is the longest time that a sizable group of immunized persons have been under observation.

That the Schick test is a reliable test of immunity, and that the use of toxin antitoxin as an immunizing agent confers permanent immunity is not perhaps fully demonstrated because of the comparatively few years since the first experimental work. However, there is reason to believe that the experience of the New York health department is sufficient justification for its general adoption. That it is an infallible method of protecting against diphtheria is not true and this should not be expected. However, if it will protect even 90 per cent of the children over a period of several years it will prove to be an instrument of tremendous value in the prevention of diphtheria.

One of the objections to the use of this method as generally practiced is the time consumed on a single person, including four visits at least. Recently Dr. Park has prepared a new toxin mixture 1/10 L plus, which proves to be less toxic than the one formerly used and, at the same time, can be read as a diagnostic test. Since immunity is not developed in any large percentage of those treated under three months this method of preventing diphtheria in the hospital is not practicable.

Hospitals Should Test Patients

However, interest in this matter among hospitals should be greater than it is. As a general public health measure, a hospital might well test all patients and immunize the susceptibles, but few hospitals are likely to be induced to do it on this ground. But there are distinct uses of this measure in every hospital. All nurses should be tested and treated, if necessary, as soon as possible after they begin their training. All house officers should be treated likewise. This practice is followed by a small percentage of all hospitals, but it should be followed out more consistently.

It is advisable to test and immunize all children whose length of stay in the hospital is likely to be three months or more. This applies particularly to orthopedic and tuberculosis wards and, for the protection of children, at least, should also be employed in all chronic hospitals and other institutions where the patients stay for a long period of time.

When pupil nurses enter for a short period of training in a contagious hospital they should have had their treatment at least three months before they are accepted.

In small cities general hospitals could cooperate with the health department and do immunization in their out-patient departments.

It is of great interest to hospitals and especially to infant asylums to know that it is pos-

sible to immunize children against measles after the children have been exposed. It consists of the intramuscular injection of blood serum taken from a person who has recently had measles.

The first experiment in which convalescent serum was employed was done by Netter of the Pasteur Institute in 1916. In 1918 Richardson and Connor reported its successful use on twenty exposed children. Since then it has been confirmed by others in United States, France, Germany, Argentine and elsewhere.

Briefly, the method is as follows: Blood is taken from someone who has recently had measles, say, within a month. The use of serum obtained from persons who have had measles years before has not been successful. The serum is then separated and can be kept in an ice box for a month. If longer preservation is desired a one-fourth per cent trikresol should be added.

To be successful as an immunizing agent, from 8-10 cc. should be given intramuscularly during the first week after the first exposure. If given later it is not likely to prevent the disease. There are no ill effects from the treatment. The immunity being passive, is not permanent. Of the patients immunized at the Providence City Hospital two developed measles at home, one in three months and one a year later.

The laity and even many physicians little appreciate how many children die of measles. The number varies between 10,000 to 15,000 in the United States yearly. The death rate from this disease is equal to that of diphtheria, the fatality rate being highest in children under five years and particularly under three. In infant asylums the fatality rate runs as high as 25 per cent in some outbreaks. While convalescent serum cannot be used as a general immunizing agent, because it is hard to get and the immunity temporary, if properly given, it will save many lives of children under five. It is not necessary to give it to other children unless they are already ill or in poor physical condition when measles might jeopardize their lives.

Already some cities are collecting convalescent measles serum and are willing to pay donors generously in order to get it. Hospitals for children and other child institutions should know about this method of stopping an outbreak and they should make provision for prompt immunization of all susceptibles, certainly under five years of age, after the onset of the first case in a measles outbreak.

New Sydenham Hospital, Baltimore's new municipal hospital for communicable diseases.

The fatality from whooping cough in children under five years of age, and particularly in those under two, is very high. It is positively criminal to expose to the disease children under five years of age, and any method by which children of this age can be protected is worthy of trial.

For several years a vaccine made of the Bordet-Gengou bacilli has been used in the treatment of whooping cough. The concensus of opinion is that as a remedy for the disease it is of doubtful value but that it may have some virtue as an immunizing agent. Favorable reports have been rather numerous but more recently its value has been questioned. If used as an immunizing agent, the vaccine should be fresh and should be given as early as possible during the incubation period. The dose should be a generous one and repeated every three days for three doses. The first dose should be at least of 500 million, the second and third of one billion.

The reliability of this method of immunization is doubtful, but it is worthy of trial on young exposed children.

Further experience with aseptic nursing in contagious hospitals confirms its practicability and safety. When first introduced into this country several persons of national prominence in the

medical profession condemned it as criminal and statements to this effect found their way into the daily press. But during recent years, while not all hospitals have adopted it, criticism has given way to acceptance in principle at least.

The technique employed in the beginning has been materially modified by experience and perhaps the change of greatest interest concerns the disinfection of mattresses and pillows and patients' clothing. Formerly these articles were looked upon as a very fertile source of disease and such they may be under rare circumstances. As a matter of fact they are of little importance in the spread of disease in an institution. For about six years at the Providence City Hospital the following has been the procedure in the disinfection of mattresses and pillows:

Mattresses and pillows are sent to the sterilizing room for sterilization by steam after cases which have died, have been taken home or transferred, when dangerously ill, and always in the case of smallpox and typhus fever, or if suspected of being infected with lice or bed bugs. Otherwise they are sunned for a minimum of six hours. If necessary, mattresses and pillows may be carefully pinned up in sheets and left in the ward corridor until collected by the ward porter. On stormy days, mattresses and pillows are sterilized by steam.

There has been no increase in cross infections and when they have occurred could be traced to active cases of the disease in question under treatment on the same floor. This discovery means very much to institutions and to the public generally. In hospitals the practice of steam sterilization led to rapid deterioration of the mattresses and pillows and rendered them unsightly after a few sterilizations, to say nothing of the time consumed and expense of the process. People in their homes can rest assured that if after contagious disease mattresses, pillows, comforters, curtains, etc., are put out in the sun and air for several hours that they will be safe to use again. It is an unnecessary expense to destroy them unless they have been soiled with secretions and discharges, and this can be avoided, to a great extent, by laying over the pillow and mattress a piece of oilcloth or rubber sheeting. It should also be emphasized that this method does not hold good for vermin. To get rid of lice, bed bugs, etc., it is necessary to sterilize by steam or soak or wash materials (infected) in a 1-60 carbolic acid solution or some other insecticide.

For an equal period of time the following procedure has been in force in disinfecting patients' clothing:

On admission when new patients are wearing their own clothing it is cared for in the following manner: The nurse takes off the outside clothing, leaving it on the truck or bedside table. The washable clothing is neatly folded and put on a sterilizing square previously placed upon the floor. After the patient has been admitted to the ward the nurse takes off her gown and scrubs. All clothing and valuables are listed in duplicate in a book for that purpose. One copy is retained by the ward and one put inside the bundle of cotton clothing. The bundle of sterilizable clothing is then pinned up and the name of the ward is marked on the outside of the wrapper. Outside clothing including hats, coats, furs, etc., are tagged with the patient's name, hung on the hanger and put out in the sun for at least six hours, after which they are listed in another book and are sent to the central clothes room, a duplicate list being sent with them. Shoes, unless left in the patients' unit, gloves, belts, and other leather goods are washed off with soap and water and are later taken to the office and a receipt obtained, which is kept in the ward. When patients are ready for discharge the same rules apply to the disinfecting of this clothing and belongings used by them during convalescence.

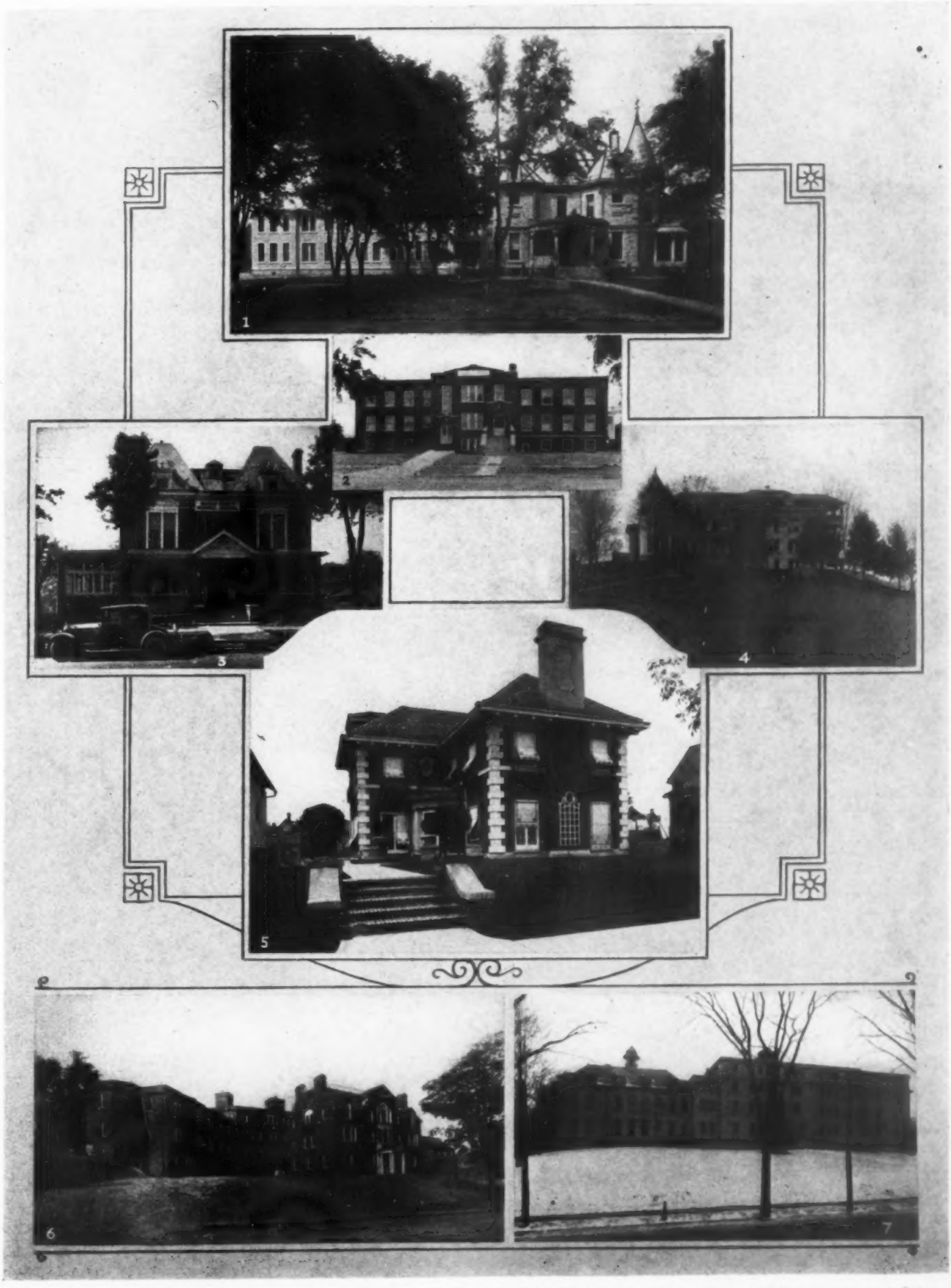
This method is economical and efficient. During a period of six years there has been no reason to suppose that patients' clothing taken care of in this way has been the source of contagion.

The most important factor in preventing the spread of infection from one group of patients to another is the careful washing of hands by physicians and nurses when going from one disease group to another. It must be done as conscientiously as the scrubbing before an operation. Experience has proved that a two minute period of scrubbing the hands in running water with liquid soap, which will make a good lather, is sufficient to remove the germs causing infectious diseases. The most useful method of timing handwashing is a two minute sand glass used for cooking eggs. It is hung on a hook near the lavatory and when washing is begun the timer is reversed and washing continued until the sand has passed through to the opposite end.

TOBACCO MAGNATE MAKES HOSPITAL BEQUEST

As a part of his bequest to educational institutions and hospitals, James B. Duke, Summerville, N. J., tobacco and power magnate, has specified that thirty-two per cent of the income from $46,000,000 is to be used for maintaining hospitals in North Carolina and South Carolina on the plan of paying to the hospitals a sum not exceeding $1 a day for each free bed occupied, and in assisting in building and equipping hospitals.

SMALL HOSPITALS OPENED DURING 1924



(1) William S. Major Hospital, Shelbyville, Ind.; (2) Tisdal Hospital and Training School, Elk City, Okla.; (3) Morgan County Memorial Hospital, Martinsville, Ind.; (4) new wing, St. Joseph's Hospital, Buckhannon, W. Va.; (5) South Side Hospital, Milwaukee, Wis.; (6) Samuel W. Brown Memorial Building, New England Baptist hospital, Boston, Mass.; (7) new addition, Meriden Hospital, Meriden, Conn.

MENTAL HYGIENE IN AND OUTSIDE THE HOSPITAL IN 1924

By FRANKWOOD E. WILLIAMS, M.D., Medical Director, National Committee for Mental Hygiene, New York, N. Y.

DURING the past year there has been an increase in the number of beds available in public institutions for the treatment of mental diseases. In some instances these beds have been made available through the opening of new hospitals; in other instances through the opening of new buildings in established hospitals. The same end has likewise been reached in some states through the extension of the parole and transfer privilege, thus making possible the more frequent use of beds already available.

There has been continued improvement in the treatment provided patients in hospitals, made possible through more adequate appropriation by legislatures. Legislatures have also shown a disposition to make hospitals more accessible to patients by the adoption of voluntary and temporary care, and observation commitment laws. These things, however, represent but normal progress. In the ordinary course of events, they are to be expected; anything less would give cause for concern.

Signposts of Progress

DEFINITE steps of progress in mental hygiene have been noted in 1924. The bed capacity of public hospitals for the mentally ill has been greatly increased. Service is better, on the whole, and adequate facilities are now available in a few large institutions.

Two events of significance are the opening of the Denver Psychopathic Hospital and the establishment of the Psychiatric Institute in connection with the medical center of Columbia University and Presbyterian Hospital in New York City.

There has been a marked increase in the number of extra-mural clinics as well as a rapid growth of child guidance clinics in several of the states.

Hospitals Lacking in Needed Facilities

It can now be said that in most public hospitals for mental disease in this country good care is being given; in an increasingly large number, fairly adequate treatment is added to good care; in a number of hospitals good treatment is added to good care. There are probably few hospitals in which it can be said that excellent treatment is added to good care. Excellent treatment can only be given where there are adequate facilities and a sufficiently large and well-trained staff of doctors, nurses, and social workers. Such conditions obtain in few public hospitals. Most hospitals are still overcrowded, understaffed and limited in clinical and laboratory facilities. With the awakening of the public conscience on these matters, however, and with the growing determination upon the part of the medical personnel in these hospitals to bring about the adoption of minimum standards for mental hospitals, the time approaches when new high levels will be reached in the public care of mental patients.

The very considerable progress that has already been made is evidenced by the fact that discussions in this field no longer concern doing away with gross abuse and neglect, but the refinement of treatment. That the general high level that has already been reached does not exist everywhere, however, is brought sharply to attention in one of the recommendations of a report made by the National Committee for Mental Hygiene of the study of the mental hospitals of a large and wealthy state. In making suggestions as to the steps the hospital authorities should take to bring the restraint of patients under supervision and control and final elimination, the director of the survey found it necessary to remark: "It is recommended that certain forms of restraint now being used should be abandoned at once, such as the use of crib beds, locked chairs, chains, etc."

Increased Number of Extra-Mural Clinics

Of greater significance, probably, than the increase in the number of beds in public hospitals for mental disease is the increase in the number of extra-mural clinics organized by state hospital services. These community clinics represent an effort on the part of the physicians of the hospitals to come to grips with their problem before the problem meets them at the door of the hospital. These clinics serve not only to maintain the health of patients on parole from the hospital but also to prevent serious illness and hospitalization by providing treatment to clinic patients showing

early evidence of nervous and mental disorder. The clinics also co-operate with local schools, courts and social agencies in handling difficult problems of behavior disorder. In Massachusetts special clinics are held for the treatment of habit disorders in pre-school children. The increase in the number of community clinics has been particularly noteworthy in Massachusetts, New York, Pennsylvania, and Maryland.

Two Outstanding Developments of Year

Unquestionably the most important events of the year have been the opening of the Denver Psychopathic Hospital and the agreement reached by the New York State Hospital Commission and the Joint Administrative Board of Columbia University and the Presbyterian Hospital for the development of a psychiatric institute in connection with the medical center that Columbia University and the Presbyterian Hospital are creating on a tract of land at 155th Street and Broadway, New York City. Two important centers for psychiatric research and teaching will thus be added to the facilities of the country.

The Denver Psychopathic Hospital is the first psychopathic hospital to be opened west of the state of Iowa. It is part of the research and teaching facilities of the University of Colorado School of Medicine and the director of the hospital will serve as professor of psychiatry in the University.

New Psychiatric Institute in New York

The agreement signed by representatives of the New York State Hospital Commission and the Administrative Board of Columbia University and the Presbyterian Hospital brings to culmination a movement that has been under way in New York State for a number of years. The new institute will make a distinct development in the efforts of the medical profession to bring about a more thorough understanding and better treatment of mental diseases. Its immediate objects will be the investigation of mental diseases and the training of doctors in the treatment of mental disorders. The hospital will have 150 to 200 beds for patients under observation. A decided advantage in the present arrangement will be the bringing of psychiatric workers in contact with general medicine. The state hospital commission plans to expend at least $1,500,000 on the new hospital and will make such recommendation to the legislature when it convenes in January. That sum is available under the $50,000,000 bond issue for state hospitals approved by the electorate a year ago.

Beaver County Tuberculosis Sanatorium, New Brighton, Pa.

The training of psychiatrists and the training of general physicians in psychiatry is an important need at the present time. With the advent of the psychiatrist into the extra-mural field an additional need has arisen for physicians skilled in the handling of rather special problems to be met with in community clinics, such as child guidance clinics, the juvenile courts, the social agencies, and the like. To meet this need in part, the Rockefeller Foundation has appropriated to the National Committee for Mental Hygiene, the sum of $40,000 for the establishment of scholarships in extra-mural psychiatry, and to the Canadian National Committee for Mental Hygiene has appropriated several scholarships for similar training. The Commonwealth Fund of New York also maintains two scholarships for physicians to be used in connection with the child guidance demonstration clinics maintained by the National Committee for Mental Hygiene as a part of the Commonwealth Fund program in the prevention of delinquency.

Two other events that indicate the direction of movement in the field of mental hygiene should be mentioned:

Three Permanent Child Guidance Clinics

Three permanent child guidance clinics have been established in Minnesota, one in Minneapolis under the direction of Dr. Smiley Blanton; one in St. Paul under the direction of Dr. M. L. Stiffler; and a traveling clinic to serve the state, with its headquarters at the University of Minnesota, under the direction of Dr. George S. Stevenson. These permanent clinics represent a cooperative enterprise on the part of the state university, the social agencies, the schools, and the juvenile court of St. Paul and Minneapolis. Their organization has followed the completion of a year's demonstration of child guidance clinic work made by the National Committee for Mental Hygiene in Minneapolis and St. Paul. A second demonstration made by the National Committee in Los Angeles closed January 1 with the organization of a permanent clinic. The Minneapolis demonstration clinic, under the direction of Dr. Lawson G. Lowrey, has transferred its activities to Cleveland, where a demonstration will be conducted for the next two years. The Los Angeles demonstration clinic has been transferred to Philadelphia, where a two-year demonstration will be made. Dr. Ralph P. Truitt, who directed the demonstration in Los Angeles, has been appointed director of the division on the prevention of delinquency of the National Committee for Mental Hygiene.

Child guidance clinics have also been organized during the year in Macon, Georgia, and Memphis, Tennessee. The organization of these clinics was under the direction of Dr. Bruce B. Robinson, director of the consulting staff of the National Committee for Mental Hygiene.

Bureau for Examination of Prisoners

A law that may prove to be the turning point in the handling of problems of delinquency was passed during the year by the Massachusetts legislature. This law provides that all individuals sentenced to a county jail for more than thirty days shall be examined by a psychiatrist assigned by the Massachusetts Department of Mental Diseases. In order to meet the requirements of this law and of a law passed in 1921, providing for the examination, by a psychiatrist, of all individuals charged for the second time with felony, the department of mental diseases has created a new bureau for the examination of prisoners.*

*State Legislation Providing for the Mental Examination of Persons Accused of Crime. By S. Sheldon Glueck. Mental Hygiene, January, 1924, pp. 1-19.

The operation of these two laws will be watched with great interest as they would seem to point the way for handling more adequately than is done at the present time, the problem of the recidivists who represent the bulk of the problem of delinquency and the problem of the mental condition of persons accused of crime which at the present time is handled in such a way as to bring humiliation to the conscientious lawyer and psychiatrist and distrust of both to the man in the street.

OKLAHOMA HOSPITAL ASSOCIATION HOLDS FIFTH ANNUAL MEETING

The fifth annual meeting of the Oklahoma Hospital Association was held at Tulsa, December 9, under the chairmanship of Dr. Fred S. Clinton, president. The meeting was divided into three sessions. The program of the morning sessions was given over to reports of officers and committee on constitution and by-laws and a discussion of the workmen's compensation act. This was the subject of an address by Mr. Phil W. Davis, Jr., attorney-at-law, Tulsa; and was discussed by Dr. Adderhold, El Reno Sanitarium, El Reno. Those attending the meeting were the guests of Dr. Fred S. Clinton at the Oklahoma Hospital, at a luncheon at noon.

The afternoon program was opened with an address, "Some Training School Problems," by Miss Salmon, superintendent, Tisdale's Sanitarium, Elk City; and was discussed by Miss Lena A. Griep, Oklahoma Hospital, Tulsa. "The Clinical Chart" was the subject of an address by Dr. L. H. Carleton, Oklahoma Hospital, Tulsa; and this was discussed by Dr. Adderhold, El Reno Sanitarium, El Reno. "The Tuberculosis Hospitals of Oklahoma" was the subject of an address by Dr. L. J. Moorman, Oklahoma City. The subject was discussed by Dr. R. M. Shephard, Talihina. The session was concluded by a round-table discussion under the leadership of Mr. Paul H. Fesler, superintendent, University Hospital, Oklahoma City, followed by a banquet at Hotel Tulsa.

The evening session, which was open to the public, was given over to the president's address and address by Dr. LeRoy Long, Oklahoma City, and musical selections by local talent.

In his address as president, Dr. Clinton briefly reviewed the history of the association, pointing out the progress it had made, especially that in respect to the support and encouragement of allied organizations in the state. In speaking of the status of the workmen's compensation act, Dr. Clinton said: "The present administration of the workmen's compensation act by the commission at Oklahoma City is grossly inadequate and far from satisfactory.

Resolutions were passed at the meeting protesting against the administration of the state industrial commission, and asking the governor to investigate the body with a view to establishing a more efficient personnel in the membership of the commission.

The following officers were elected: Dr. Fred S. Clinton, president; Dr. McLain Rogers, Clinton, vice-president; Dr. A. S. Risser, Blackwell, second vice-president; Mr. Paul H. Fesler, Oklahoma City, secretary-treasurer. The next meeting will be held in May, 1925, at Tulsa.

PROGRESS OF PHYSIOTHERAPY IN 1924

By JOHN S. COULTER, M.D., Chicago, Ill.

SINCE the World War physical means of treating diseases and injuries are being used more and more in hospitals and by physicians and surgeons in their offices. Until recently the physiologic and pathologic actions of these remedies were largely mysteries and their uses empirical. In the last two years research work has started to solve the mysteries, and in 1924 more work has been done along this line than in any previous year. In this article we will briefly review some of the more important advances in 1924.

Many forms of extra-pulmonary tuberculosis yield to treatment with sunlight and artificial light radiation. Lupus vulgaris of the skin healed by combined local and general light exposures in nearly 90 per cent of the cases[1].

In children ultra-violet rays have special value in the treatment of peritoneal and glandular tuberculosis. Of the glandular forms the mesenteric is the most rapidly improved, and then the mediastinal and the peripheral.[2]

Heliotherapy as an adjunct to outdoor air and mechanical fixation, in the treatment of tuberculosis of joints, is definitely proved.

The discharge decreases, the pale granulations take on a healthy color and the sensitiveness diminishes[3].

Opinions Differ on Value of Light Rays

In pulmonary tuberculosis the opinions in regard to the use of light rays differ. Rollier started treating patients by direct exposure to the sun twenty years ago and has recently published a book on this subject advocating its use.[4] Chapman gives favorable results in 100 cases with the use of ultra-violet rays.[5]

Several have observed a large number of instances of rapid progress in pulmonary tuberculosis from overdoses of sun rays and they conclude that only torpid stationary cases are suitable for this treatment, and it is contraindicated in the presence of smouldering activity of the tuberculous process (fever), hemoptysis and other signs of activity.[6]

Genito-urinary tuberculosis is favorably influenced by sunlight, the pathological process is arrested and it seems to promise a cure.[7]

The treatment of rickets with light rays is of recent origin. Hess and Unger were pioneers in this work and workers in the treatment of this disease have done much to show the effect of this form of radiant energy.

The rays themselves can at best penetrate only a short distance through the surface layers of the body. It has been argued recently that the ultra-violet radiations, which cause large amounts of calcium and phosphorus to be retained in the organisms of rachitic infants, affect absorption from the intestine. As a direct action on the intestine or its contents seems out of the question with rays that penetrate the skin to a depth of not more than 1 mm., one must assume that, as a result of the action on the ultra-violet rays on the skin or on the blood in the capillaries of the skin, the physical or chemical condition of the blood is in some way altered.

In studying the effects of light on the organism, Cramer and Drew of London found that animals kept in a dark room from birth do not show any

Advances in Physical Treatment

"IN the last two years research work has started to solve the mysteries of physiotherapy, and in 1924 more work has been done along this line than in any previous year."

Treatment by ultra-violet rays has proved of value in cases of peritoneal and glandular tuberculosis. Heliotherapy as an adjunct to outdoor air and mechanical fixation in the treatment of tuberculosis of the joints, is definitely proved. The use of ultra-violet radiation in the treatment of hay fever and bronchial asthma has increased, although it is only in the experimental stage.

There has been increased use of light rays in the treatment of rickets.

Hydrotherapy continues to be more universally used in treating nervous patients and in institutions for the mentally ill.

1. Mayer: Artificial Light Therapy in Tuberculosis. J. A. M. A., June 14, 1924.
2. Gerstenberger and Wahl: Ultra-violet Ray Therapy in Peritoneal and Glandular Tuberculosis of Children." J. A. M. A., Nov. 22, 1924. Robertson: Quartz Lamp Treatment, Tubercle (London). August, 1924.
3. Orthopedic Surgery: Jones and Lovett. Sequeira: Artificial Light Baths in the Treatment of Tuberculosis. Brit. J. Tuber, July, 1924.
4. Rollier: Heliotherapy.
5. Chapman: Suggestions for the Treatment of Pulmonary Tuberculosis by the Ultra-violet Ray. J. Radiol, July, 1924.
6. Stephani: Dangers of Heliotherapy, Schweizerische medizin Wochen. Basel, Feb. 28, 1924. Hudson & Hill: Clinical Observations on Heliotherapy in Pulmonary Tuberculosis. Lancet, London, June 7, 1924.
7. Myll: Heliotherapy in the Treatment of Genito-Urinary Tuberculosis. J. A. M. A., Dec. 6, 1924.

obvious signs of ill health. They do differ from the normal; and the difference manifests itself morphologically by an abnormally low number of blood platelets. Exposure of the animals to radiation from a mercury vapor lamp was followed by an augmentation of the platelet count. Light, therefore, seems to have a stimulating effect on the formation of blood platelets. Cramer and Drew are more inclined to the view that these blood cells are formed by the endothelial cells of the blood vessels and lymphatics. On this basis, the described effect of light might be attributed to a local stimulating effect of the rays on the endothelial cells of the peripheral vessels.[8]

The light rays seem to supply something analagous to food factors in rickets.[9]

Radiation acts as an irritant to the tissues resulting in congestion, increased outflow of immunizing lymph and increased phagocytosis. Any irritation of the skin increases the defensive powers of the blood.[10]

That inert fluids can be given antirachitic properties of by ultra-violet rays has been recently demonstrated."[11]

Hay Fever and Bronchial Asthma

Novak and Hollender conclude that sensitization to proteins or other products precipitates the asthmatic or vasomotor attacks, the underlying basis being a deficit of blood calcium and probably inorganic phosphates. They treat these cases by raising the calcium content of the blood by the use of ultra-violet radiation. This study is only in the experimental stage.[12]

Methods of Light Treatment

Direct sunlight is used by Rollier and many others but can be little used in our cities so that artificial forms of light have to be used. Finsen uses the carbon arc and this gives a spectrum most closely approaching the sun with a preponderance of infra-red and longer ultra-violet rays.

In America the quartz mercury vapor light is most used for giving more of the shorter ultra-violet rays. There seems to be no difference in the therapeutic results, and the mercury quartz light is certainly easier to use, and the exposures take less of the patient's time.

Later Uses of Diathermy

Diathermy is the production of heat between two electrodes of a high frequency machine due to the resistance of the tissues. The current has an oscillation frequency of one to two million a second. It produces no contraction and no other sensation than heat.

Diathermy is most useful in acute injuries. Pain is reduced in many cases during the first twenty-four hours and many are relieved of pain in less than one week's time. In cases of simple fractures diathermy is a most valuable analgesic during the acute painful stage.[13]

Corbus and O'Conor regard diathermy as a specific for gonorrheal epididymitis.[14]

They reported thirty-five cases of gonorrheal endocervicitis treated with diathermy with a special electrode and said it has been far more successful than any previously tried technique.[15]

Stewart says the number of cases of the use of diathermy in pneumonia reported is still too few to justify definite statements as to lowered mortality but the symptomatic relief is so marked as to justify its use in connection with our other methods.[16]

Lacey says that diathermy simplifies the treatment of pneumonia, and is far more acceptable to children than dosage with drugs, and that it shortens convalescence.[17]

This subject is still in the experimental stage and all observations are clinical. Diathermy is deep heat, and from our clinical observations it does give symptomatic relief, but we have seen no other effects from its use.

Diathermy is indicated for most affections of the joints (excepting tuberculosis) such as arthritis deformans, gout, and chronic rheumatic polyarthritis. For gonorrheal arthritis it should not be applied until the acute phenomena have disappeared.[18]

Surgical diathermy is apt to be confused with the actual cautery. There is an important difference—the cautery burns and there is a danger of immediate or secondary hemorrhage, while in surgical diathermy the tissues are coagulated so that there is an absence of all hemorrhage at the operation and no danger of secondary hemorrhage.

In bladder tumors it has proved most valuable.[19]

Heat, Exercise and Massage

Although massage is one of the oldest physiotherapeutic measures, it has received little scientific attention. This year Pemberton and his

8. Edit. J. A. M. A., Jan. 19, 1924.
9. Edit. J. A. M. A., March 8, 1924.
10. Colebrook, etc.: The Effect of Radiation on the Bactericidal Power of the Blood. Brit. J. Exper. Path., April, 1924.
11. Hess & Weinstock: Antirachitic Properties Imparted to Inert Fluids by Ultra-violet Irradiation. J. A. M. A., Dec. 6, 1924.
12. Novak & Hollender: A New Treatment for Hay Fever Based on the Calcium Content of the Blood Serum. Ill. Med. Jour., April, 1924.
13. Holmblad: Treatment of Injuries During the Acute Stage by Diathermy. J. A. M. A., June 7, 1924.
14. Corbus and O'Conor: Diathermy—Specific for Gonorrheal Epididymitis. J. Urol, August, 1924.
15. Corbus and O'Conor: The Treatment of Gonorrheal Endocervicitis by Heat. Surg., Gynec. & Obst., January, 1924.
16. Stewart: The Use of Diathermy in Pneumonia. Inter. Clin., September, 1924.
17. Lacey: Medical Diathermy in Pneumonia of Children. J. Radiol., Sept., 1924.
18. Berger: Diathermy. Polska gaz lek Cracow, June 8, 1924.

co-workers at the Presbyterian Hospital, Philadelphia, have investigated the physiologic effects of massage. Massage is almost always preceded by some form of external heat. These same workers found that exposure of the body to external heat produced, in addition to the profuse sweat familiar to every one, a heightened circulation, increased pulmonary ventilation, increased percentage saturation of the venous blood with oxygen resulting from increased blood flow, an increase in the alkalinity of the blood, an alkaline urine and a change in the reaction of the sweat from its initial point to a reaction less acid or more alkaline. These changes in reaction are brought about by a loss of acid from the body, chiefly carbon dioxid, through the lungs, urine and sweat in the order of magnitude named, which results in a relative excess of alkali. This excess of alkali alters the reaction of the blood and is then eliminated through the urine and sweat, producing the swing towards the alkaline range in the fluids mentioned.

Exercise and Heat Exposure Contrasted

The recent researches of Barr and his co-workers have demonstrated that exercise is accompanied by a state of affairs opposite to that following exposure of the body to heat. The actively contracting muscles produce lactic acid in amounts sufficient to change the acid-base equilibrium and reaction of the blood for as much as fifty minutes or more after vigorous exercise, notwithstanding the compensatory hyperventilation and removal of carbon dioxid.

Their conclusions on their investigations of massage are:

(1) Massage of voluntary muscles, even though vigorous, is not accompanied by the evidences of lactic acid production, and acidosis, which accompany relatively mild active exercise of short duration, or by the evidences of loss of acid and alkalosis, which follow exposure of the body to external heat.

(2) Massage can be used as a partial substitute for active exercise in many conditions, but its benefit must be due chiefly to some mechanism other than that reflected in the chemical changes accompanying exercise. The available evidence suggests that these benefits are referable to changes in the circulation, especially capillary.

(3) The favorable influences on the rheumatic syndrome of exposure to external heat, massage and active exercise apparently find their chief explanation in their influence on the circulation, including the capillary beds. The corollary to this is that a disturbance of the circulation constitutes part of the underlying pathologic change in rheumatic and arthritic conditions.[20]

Bazett made a study of the effects of baths on man and this first article deals only with the effects of the temperature of the bath.

Pulse rate went up if the water was hot, and this rise was generally more or less proportional to the rise of body temperature. As the bath felt definitely warm when entered, it usually produced some skin hyperemia and generally caused a fall of both systolic and diastolic blood pressures, varying from 0 to 10 mm. Hg. A considerable diuresis is observed in all baths, cold as well as neutral or warm. There was no evidence of any water absorption through the skin. In hot baths a very marked hyperpnea, gradually becoming more severe until it amounted to dyspnea, was seen. An increase in the hemoglobin percentage was observed in hot baths where there had been extreme and continued sweating.[21]

Anders' Review of Hydrotherapy

Anders gave an excellent review of the indications for hydrotherapy. He believes the best substitute for the cold tub baths is the cold pack which should be used in severe types of typhoid and other fevers at intervals of four hours, if necessary, followed by gentle friction. A temperature of 102.2 degrees F. or above is an indication for the use of cold applications.

In influenza he gives a sponge bath with friction at three hour intervals—first bath at 90°, each subsequent bath reduced 3° until down to 75° F. This to be accompanied by drinking four ounces of water every three hours.

For pneumonia he uses ablutions to front and sides of trunk and extremities every three hours, first at 80° and reduced to 70°.

In tonsillitis an ice collar or piece of flannel wrung out of ice water may be applied.

In neurasthenia a tub bath at 95° at bedtime is recommended, then a tepid tub or sponge bath in the morning followed by active friction of the skin.

In the treatment of rheumatism and gout he uses the warm pack, Turkish bath or hot air bath.

In chronic nephritis he uses the warm tub daily or the electric cabinet bath on alternate days.[22]

DR. GREENBERG HONORED AT DINNER

A dinner attended by a large group of hospital and medical men was held in Boston, Mass., December 1, in honor of Dr. Boris E. Greenberg, who has recently completed five years of service as superintendent of the Beth Israel Hospital, Boston.

19. Walther and Peacock: Diathermy in Urology. J. A. M. A., Oct. 11. 1924.
20. Pemberton, Cajori and Crouter: The Physiologic Effect of Massage. J. A. M. A., Nov. 29, 1924.
21. Bazett: Studies on the Effects of Baths on Man. Am. J. Physiol., Oct. 1, 1924.
22. Anders: The Indication for and Methods of Employing Hydrotherapy. J. A. M. A., July 26, 1924.

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HOSPITALS IN THE AIR

EVERYTHING which man has created was first built in the human brain. The arboreal dweller conceived the greater comfort of the cave and the cavedweller erected houses in his mind before they were raised on terra firma; the harnessing of air, water and fire, the subjugation of electricity, the chemical forces of nature and the stubborn rocks and metals to man's will first took place within the imagination of some human being. In other words, some one dreamed and thus performed the first act in creation; the castle in the air became a reality.

To call an individual a dreamer is to dub him impractical; he is classed as a visionary. Yet, those who have had the courage to translate their dreams and visions into the solid and tangible things of life are the world's greatest and those who cannot create in their imaginations are the reactionary non-progressives of human society.

But it is not enough to build a hospital in the air, even though this be the all important first step. Courage and faith are required to tell the vision to others and work is needed to bring the dream to pass. It is one thing to long for new apparatus, improved machinery and modern means of treating the sick; it is another to bring about their accomplishment. The man of action must supplant the dreamer, if creation is to follow.

Many dreams fail because of a lack of confidence in them. If we cannot fight with fortitude, we show an absence of faith and without faith the mountains of ignorance, stupidity and selfishness cannot be moved. The Panama Canal was a dream, a glorious and wonderful vision for four centuries before faith and fortitude moved the mountainous backbone of a continent, tore the hemisphere asunder and let the waters in.

We who are tied down by the detail and tedium of hospital administration in its multitudinous phases are too apt to suppress our dreams for better buildings, better equipment and improved methods. We fear to be visionary; we lack the courage to strive for anything beyond the bare necessities of the present. It requires greatness to fight for the doubling of bed capacity, for better trained, better paid personnel, for modern equipment. The greatness of vision which makes dreams come true, the greatness which those to whom is committed the welfare of ailing minds and bodies must have, is a faculty capable of development, if we will but dream, and dreaming, do. Let us then dream, visioning a bigger, broader field of usefulness and let us also cultivate that spirit which will crystallize the filmy substance of those dreams into the material realities of a better, safer, more efficient world.

PICTURE PUBLICITY

THIS is a press agent age. In the eyes of the world the man succeeds most nobly who appears oftenest in print. A governor, nay a president, it seems, is no greater than his press agent. Aping the prima donna, the man of affairs now travels from coast to coast, his brief case bulging with photographs of himself in selected poses; these, he dispenses modestly, if urged, and insistently, if ignored. His solitary rambles, his journeys by train are silent rehearsals of wise, of witty, of startling remarks calculated to set reporters' pencils and avid newspaper readers agog.

The results have become loathesome to the intelligent reader. And yet this clamor for publicity is but a reaction from the tight-mouthed conservatism of the preceding age, an age which fed upon the thoughts of others and gave out nothing in return. The hospital, along with other public institutions, were parasitic. It fed on the public treasury or public subscriptions and obscured its achievements in labored annual reports. But now the hospital is awakening to its news obligations. It is catching the press agent spirit. It need not fear the excesses which are sickening the public against self-advertising. The pendulum need not swing its full arc from silence to sensationalism. But the hospital owes the public its legitimate news and should court the dignified presentation of its happenings, its innovations and its achievements.

Photographs are perhaps the hospital's greatest publicity aid. Good pictures will carry a poor story. An excellent manuscript has often found final repose in the editor's wastebasket for the sole reason that it lacked illustrations. The alert superintendent will cultivate an "eye for pictures" as he will a "nose for news."

Human interest is the significant requirement of the photograph. Pictures are bait to catch the reader's attention and unless they live, the reader will conclude that the article which they accompany is dead. The lay eye is not drawn to a vista of unoccupied ward beds, however faultless the technique in their making. If there peered from among the pillows a roguish-eyed pickininny with ebony face in sharp contrast to the spotless sheets, or a head with a crooked smile emerging from sundry bandgages, the picture would have a center of attraction irresistible to the eye. Nor is there any appeal to the casual reader in a lonely nurses' sitting room or an operating room with catalogue equipment. Group some nurses about piano and fireplaces, strap a patient on the operating table with gowned and masked attendants in position, and there are two photographs that will challenge attention. Pictures which depict pain or suffering are, of course, bad taste as well as poor psychology. Those containing children are most universal in their appeal.

Many hospital executives with irritating disregard for printing requirements face all publicity demands fortified by a single and battered halftone cut of the institution. This upon request for illustrations they confidently and indiscriminately dispatch to magazines or newspapers; later, when it is returned unused, they express wonder. Ten minutes with a book on photographic reproduction would convince them of the absurdity of their expectations. The quality and finish of print paper is the gauge for halftone screen measurement. It were better for the superintendent to retain his cherished cut for the exclusive use of the hospital and send good photographs; magazines and newspapers will finance their own engraving.

Hospital photography is a wide and interesting field and its value in publicity is not to be despised. The wise superintendent will look to it that he does not ignore its possibilities or the mechanics of its use.

WHY NOT PICTURE BULLETIN BOARDS FOR PATIENTS UNABLE TO READ

A few years ago hospitals recognized the value of occupational therapy as a curative agent for the convalescent and chronic patient. Today we are going a step further in trying to shorten the hours of the hospital patient by providing books for those who are able to read. The therapeutic value of wisely chosen books is now universally recognized and a large number of hospitals make an effort to provide suitable books for patients and even employ a hospital librarian for this purpose.

The reading of books is a most beneficial pastime for a large number of patients but what of the remaining large numbers who are unable to handle books and yet long for some sort of amusement to relieve the monotony of the four walls? For these patients, we have done very little except, in some institutions, replaced the drabness of the colorless walls by cheerful, tinted walls and, perhaps, a few pictures.

Hospital librarians are familiar with such remarks as "I could not read the magazine because I was too tired to hold the book." Such a patient who is unable to turn the pages of books still wants to seek diversion through his eyes. Even if he has the opportunity of the radio his

ears grow weary of listening in and his eyes, because most of us are eye-minded, are still the agents of the primary pleasure sense. Why not provide traveling picture bulletin boards, such as are seen in many public libraries, for this class of patients?

RUNNING THE ENGINE IDLE

AN engine which keeps on running after the load is taken off is an economic liability. It is consuming heat-units and lubricants. It is wearing out its parts. It is producing nothing but expense. If this process is continued long enough, the engine must be scrapped and replaced by another.

It is even so with the worrier.

Worry is the non-productive running of the mental engine, consuming the energy of soul and body and wearing out uselessly the vital faculties before their time. It is that most horrid child of fear, faithless cowardice, and it is the parent of mental confusion, irritation and dis-operation. It apprehends misfortunes which never occur, foresees dangers which are non-existent, attributes to others motives which they have not, and weakens the ability to cope with situations when they arise. It begets that most irritating of human characteristics, nagging. It begins as a simple parasitic new-growth. It ends as a destructive, malignant cancer of the soul. Thus it is a chronic sapper of vitality which eventually becomes a destructive incurable malady.

In its earlier stages, it is easily recognized, but it is of such continuous, steady growth that only an heroic exterpation will effect a cure, once it has gotten a firm foothold.

Its preventive is faith—faith in one's self, faith in one's job, faith in one's God. Its cure is that philosophy of life which recognizes the time-proven fact that the ills we fear rarely occur and that the soul of man is never called upon to carry a burden which it cannot bear. Time solves most problems. There is no situation, no matter how hard it may be, which will not pass. None of us are as important parts of the cosmos as we think we are. If our mission in life is useful, it will go on without us. None of us is absolutely essential to the scheme of things.

The life of the hospital administrator or institutional worker is beset with many irritations, if he will allow them to be irritations. Slovenly minded employees, wanton gossipers, dissention fomenters, trouble hunters, strife stirrers, the misfits of the community and all that ilk that are unable to cope with the competition of the world seek the encloistered haven of institutional life. They combine with the vagaries of the medical staff, the pestilential interference of practical politics, the ultra-conservatism of a board of directors, the necessities of the exchequer and feminine jealousies to strew tacks on the path of progress. They are arch-producers of worry if we will but let them worry us. But what does it matter if a tire is occasionally punctured, provided we carry a spare and keep on going?

Work—constructive, honest toil—is the antidote for worry. Equally valuable is play, the process by which we turn off the engine and recreate the power with which to do tomorrow's task. Another ingredient in the formula of prophylaxis is an interest in other people, their jobs, their hopes, their games, their sorrows, and their joys.

The worrier cannot achieve greatness because worry is pettiness. Success is not his because worry is inefficiency. Happiness does not abide in him because worry is sorrow over what never happens. Therefore, let us consume our own smoke and walk fearlessly forward in the serene faith that tomorrow's ills will be surmounted and that the misfortunes of life are the best material for the construction of a stairway to the higher levels, closer to the serenity of the stars.

In Memoriam

In the death of Dr. Andrew R. Warner, who departed this life on Thursday, November 27, 1924, the American Hospital Association and the hospitals of North America sustained a great loss. He was president of the association for the year 1918-1919 and executive secretary for five years and was unfailing in his activities and interest in its behalf.

He was active and generous in his support of all that stood for the best in life. He was a man of high ideals. His honor was never questioned and his name stood for the highest integrity and a square deal in the hospital world.

His many virtues will live long in the minds and hearts of those with whom he came in contact.

Be it resolved, That this testimony to the worth of our departed friend be published in the twenty-sixth annual proceedings of the American Hospital Association, and that we extend to his bereaved family our sincere sympathy in their great affliction.—Extract from minutes of the board of trustees meeting of the American Hospital Association, held December 15, 1924, at the headquarters of the association, Chicago, Ill.

DR. WARNER'S INFLUENCE IN THE HOSPITAL FIELD

A GREAT loss came to the hospital field in the death of Dr. A. R. Warner, executive secretary of the American Hospital Association, on November 27, 1924, after a prolonged illness of several months. Ever since his graduation from Western Reserve Medical School in 1905 Dr. Warner had been actively engaged in hospital work and was especially interested in organized hospital activities in the service of which his influence was widespread throughout the entire hospital field.

The late Dr. A. R. Warner

He was born in Pulaski, N. Y., in 1875 and was graduated from Hamilton College, Clinton, N. Y., in 1899, and from Western Reserve University Medical School, in 1906. He served his internship at Lakeside Hospital, Cleveland, Ohio, where he later became assistant superintendent from 1911 to 1913; acting superintendent until January, 1915, when he was elected superintendent of the hospital and remained in that capacity until November, 1919. He then assumed the position of executive secretary of the American Hospital Association. During his six years at Lakeside Hospital, Dr. Warner initiated and assisted in the conduct of a number of pioneer activities both in the hospital field and in civic welfare.

A Founder of the Cleveland Hospital Council

He was one of the founders of the Ohio Hospital Association and the Cleveland Hospital Council and carried the major part of the burden of organization of the Cleveland Council during the early years of its existence. While at Lakeside Hospital he accomplished much in the shaping the development of dispensaries not only in Cleveland but throughout the entire country. It is largely through his influence that a broader conception of the functions of the dispensary has grown in this country. Together with his coworker, Mr. Michael M. Davis, Jr., executive secretary, Committee on Dispensary Development, New York, he wrote a book, "Dispensaries, Their Management and Development." His interest in civic welfare was shown by his active participation in work of this nature in Cleveland. He worked with the federated churches during their campaign which resulted in the elimination of the segregated district in that city.

Dr. Warner will be remembered by what he did in devising a method for the purification of nitrous oxide gas as an anesthetic. The use of this gas as an anesthetic was just beginning while he was at Lakeside Hospital and it is conceded that his method of purifying did more than any other toward making it a safe anesthetic. Lakeside Hospital has patented his method so as to hold the method from commercial exploitation and at the same time have the process available for any hospital desiring to make its own gas.

During the war he not only carried on the routine of the hospital but, in spite of the handicaps of the time, was able to develop the research side of the hospital to such a degree that the War Department considered that hospital one of the regularly established research centers for the chemical warfare service.

From the beginning of the American Hospital Association he took an active part in its development and served on a number of special committees. He served as president of the association from 1918 to 1919 when he was elected executive secretary, which position he held until his death. Largely through his leadership as executive secretary the association has developed in membership and in influence throughout the entire field.

Dr. Warner also took an exceedingly active part in the organization and development of the American Conference on Hospital Service and ever since its organization served as its vice-president.

ROUTINE PRACTICAL APPLICATION OF CLINICAL PHOTOGRAPHY*

By KANO IKEDA, M.D., Pathologist, Minneapolis General Hospital, Minneapolis, Minn.

THE purpose of this paper is not to present a discussion on the science and art of medical photography and its application as it is found in medical colleges and leading hospitals and clinics of this country, but to show how simple clinical photography may be practically applied by the average hospital for the betterment of its routine clinical records.

It is clearly recognized that one of the important criteria of a modern hospital lies in its clinical records. The American College of Surgeons has championed the cause of the standardized clinical records along with its vast program of hospital standardization, and the importance of a thorough and systematic clinical history and physical examination in the diagnosis of disease is being consistently emphasized by medical teachers.

Essential changes in the clinical records thus brought about during the past ten or fifteen years may be summarized as: first, the more scientific arrangement and classification; second, the more complete history, physical findings and therapeutic notes; and third, the more varied and extensive pathological and roentgen reports. In short, these records are no longer mere bedside notes but have become complete scientific annals of individual cases.

In spite of the advance thus made in the average record, one is often tempted to offer some criticism concerning its construction and contents in general. The clinical history of today, especially that obtained by the young medical man, is so voluminous and full of non-essentials that one is required to spend considerable time in reading and digesting the contents before arriving at any essential conception of the case. Writing peculiarities, careless literary construction and over-emphasis of non-essentials, etc., not to mention inherent individual literary short-comings, have caused an unlimited amount of obstacles in visualizing the case under study. Furthermore, it is generally acknowledged that many a well written, lengthy report on roentgen examinations or pathologic specimens fails to convey a definite mental picture of the condition reported. In a fracture case for instance, an average clinician does not take the time to read or study the roentgen report but immediately asks for the original roentgenograms, simply because the intimate study of the plates themselves gives an infinitely more accurate conception of the condition under observation than does the mere reading of its abstract report.

When a patient is discharged, his clinical record is permanently filed away after due classification and indexing; while his roentgenograms or surgical specimens, if any, are separately and independently stored away by the respective departments. With a few unusual exceptions, these are destroyed within the course of from a few months to a few years. Economic consideration practically prohibits a permanent preservation of the original specimens and roentgenograms by the average hospital. Conditions amenable to surgical excision or other therapeutic measures as, for instance, visible tumors or deformities and skin lesions, etc., are forever lost. Their descriptive sketches alone are preserved somewhere in the clinical records which are, as a rule, incomplete and ambiguous.

Parenthetically, the writer wishes to emphasize the importance of incorporating a comprehensive summary of the history of each case written or dictated preferably by the attending physician or the chief resident before his discharge. This discharging summary should best be typewritten on a special form.

Under these conditions, the only permanent report which conveys a visible clinical condition appears to be its direct or indirect photographic reproduction together with such appropriate description as is essential in its further appreciation; namely, consistence, weight, color, etc., when necessary. For all practical purposes, such as a photographic reproduction would seem almost as valuable as the original, especially in roentgenology.

Leading clinicians have long realized this fact. Their private records undoubtedly include many an interesting and instructive clinical photograph which is highly valued as a graphic record of their own professional achievement or of a rare and priceless specimen in medicine. Medical schools, as a rule, maintain a department of medical art and photography which materially contributes to the system of visual education.

How Photographs Are Incorporated in Record

On the other hand, the average hospital, as far as the writer has been able to determine, has made no attempt to recognize the part photography has come to play in the practice of medicine and is still delegating it to the initiative of the individual physician. With these considerations in mind, the writer undertook to find a means of permanently incorporating into the clinical record of all the photographically reproducable conditions referred to in the diagnostic laboratories of a hospital, such as

Clinical Record Photographs

SINCE clinical records are no longer mere bedside notes but complete scientific annals of individual cases, they should contain in the most concise form knowledge that is needed by the investigator. Often reports as to roentgen examinations or these describing pathological specimens do not convey a definite mental picture of the condition reported.

For this reason it has become practical to incorporate photographic reproductions with the summary report of cases. These prove as valuable as the original, especially in roentgenologic cases. The advantages of keeping such photographs in reports is apparent in the different branches of medical service. The method is being successfully used and may be carried out in almost any hospital or clinic.

*The writer wishes to acknowledge the cooperation and encouragement of Dr. Walter E. List, superintendent of the General Hospital, Minneapolis, Minn., which made the realization of this undertaking possible.

roentgenograms, pathological specimens, electro-cardiograms, cardiac tracings, anomalous conditions and dermatologic lesions.

This was easily accomplished by mounting the photographic print of such a condition on an appropriate holder of a standardized size especially designed for this purpose. The mounted photograph was then incorporated into the bedside record of the patient with the appropriate addenda such as, the name of the patient, his register number, the service and the physician in charge, the part reproduced and the diagnosis. In the course of his daily round, the clinician is thus furnished not only the carefully prepared written report but also a photographic reproduction of the condition thus reported. He is able to see graphically, the result of his own operative effort in the light of an unprejudiced and accurate photographic reproduction of the original. A post-operative course is more intelligently discussed by the aid of the visual record of a pre-operative appearance.

Advantages of Incorporating Photographs

The undertaking has been found highly satisfactory and received favorable comments from the members of the hospital staff. Briefly, some of the more outstanding advantages of this method may be here summarized:

Surgical service: Photographs of surgical defects or anomalies before and after the operation, such as goitre, tumors, hernia, cleft palates, hare lips, deformities of limbs due to nerve or bone injuries, etc.; photographs of fracture beds and appliances; photographic reproduction of roentgenograms of fractures, empyema, gastro-intestinal lesions before and after the surgical interference and at the time of discharge.

Medical service: Photographic reproductions of roentgenograms of pulmonary, cardiac and gastro-intestinal diseases which may serve well as a pictorial guide in the physical diagnosis; photographs of facies, skeletal anomalies, and structural changes due to an endocrine or systemic disturbance; electro-cardiographic and pulse tracings.

Gynecologic and obstetric service: Photographs of pelvic tumors in situ or after removal; photographs and x-ray reductions of the bones of the spine and pelvis in cases of pelvic and postural deformity in pregnancy; photographs and roentgenograms of fetal anomalies and monsters; photographic reproductions of roentgenograms of the fetal positions and presentations in pathologic pregnancies.

Genito-urinary service: Reproductions of pyelograms, urinary calculi, foreign bodies, etc.; photographs of renal and vesical tumors.

Orthopedic service: Photographs and roentgenographic reproductions of postural and bony deformities and anomalies before and after correction.

Dermatological service: Various skin lesions before the after treatment.

Roentgen service: Photographic records of cases undergoing roentgen and radium therapy.

Pathological service: Photographs and photomicrographs of surgical and autopsy specimens which are to be incorporated into the clinical chart.

Educational service: Photographs and lantern slides of typical as well as unusual conditions selected, classified and cross-indexed for future reference. They are used as illustrations in demonstration and teaching.

Medico-legal service: In the loss of the original, the photographic record may become a priceless value to the physician or the hospital in a medico-legal suit. This cannot be overemphasized.

A practical application of the clinical photography is easily carried out by any hospital or clinic. The original cost and up-keep of the equipment, and the cost of operation is within the reach of every progressive hospital. The technician need not be a professional photographer. The laboratory or roentgen technician can easily qualify to do the work satisfactorily. Essentials in amateur or home photography is all that is required to know. A happy arrangement would be to delegate this work to the x-ray department, in as much as a part of the photographic equipment is already in use in the dark room. It is well, if practical for the roentgenologist, pathologist or the attending physician, to localize the condition to be accentuated or designate specific points to be emphasized in the photograph or the x-ray reduction. The technician, however, will soon become adept in the work and be able to carry on independently except in rare instances.

Essential Equipment and Supplies

Here are mentioned the equipment and supplies essential in conducting such an enterprise.

1	Clinical camera (complete including stand, two flood lights, enlarging back, lantern slide back)	$175.00
1	reducing camera	137.00
6	film holders, 5x7 at $2.00	12.00
10	film developing hangers, No. 4, 5x7 at $0.50	5.00
6	lantern slide plate holders at $2.25	13.50
1	R. O. C. trimmer, No. 2, 1-inch	3.75
1	majestic drying roll	5.00
3	enamel trays, 10x12 at $2.50	7.50
1	printing machine	17.50
2	developing and fixing tanks, 3A at $6.00	12.00
3	squeezee boards at $0.93	2.79
1	squeezee roller	3.00
		$396.00

Principal current supplies consist of films, slides, photographic papers, chemicals for developing and fixing solutions, etc.

Process films, 5x7 (for reduction) per dozen	$1.23
Portrait films, super speed, 5x7, per dozen	1.23
Azo paper (glossy) single weight per gross	2.30
Lantern slides, per dozen	.44
Lantern slides cover glass, per dozen	.35
Lantern slide binders and mats	.60

A few other supplies such as two 6x6 black cloths for back grounds, two 3x3 cloths for focussing and a film filing cabinet, an index box can easily be added at a nominal cost.

Thus, an approximate cost of a single photograph or an x-ray reduction including a film, printing paper and mounting paper is about thirteen cents. A lantern slide fifteen cents. These figures do not include the cost of labor, general up-keep depreciation etc., as well as the original cost of permanent equipment.

The commercial phase of this service is not considered here. However, it may be legitimately stated that the service can at least be made self-supporting by issuing at a nominal cost to the physicians such photographs or lantern slides as are of personal interest to them.

Technician May Take Charge of Photographs

As a non-professional who knows little of the science of photography and who is further handicapped by the limited equipment, the technician is not expected to turn out photographs of the highest quality in every case. However, her efforts will be rewarded in at least ninety per cent of the cases submitted which makes it highly worth while as a routine measure. It is hoped, however, that future technicians in roentgenology may consider it their sphere of activities to include technic in simple medical photography and train themselves accordingly.

The writer has purposely omitted mention of microscopic photography or photomicrography. The technic is slightly more complicated and there is an additional cost of equipment totaling $200 to $300. While highly desirable, this should be left to the combined judgment of the pathologist, the staff and the management of the hospital.

In conclusion, the writer wishes to emphasize the following points:

(1) That medical photography as a science or an art is not discussed or considered in this paper; (2) that a permanent pictorial record as a part of the clinical history is deemed highly desirable as a routine measure; (3) that a simple method of executing such a measure into practice by the aid of clinical photography is discussed and explained; (4) that such a practice is within reach of the average hospital or clinic and, therefore, earnestly recommended for adoption for the sake of a better clinical record.

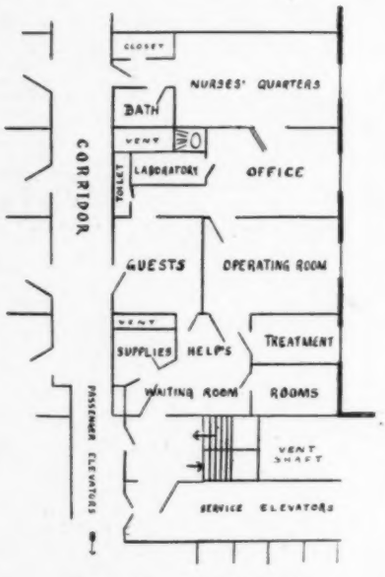
THE MODERN HOSPITAL SUITE OF THE NEW HOTEL ROOSEVELT, NEW YORK, N. Y.

By S. B. ROSS, M.D., Resident Physician, Hotel Roosevelt, New York, N. Y.

WHEN an active manufacturing community attains the size of about 2,500 inhabitants, one of the first civic improvements to be considered is the establishment of a small hospital. Long before this has been thought of, however, the services of a nearby physician have been called upon frequently, and the inconvenience of this arrangement soon becomes apparent. The local doctor may group himself with other physicians and utilize a small place where sickness and infirmities can be properly taken care of, but, nevertheless, it is some sort of a hospital and the growing busy population demands that there be such a place.

The large modern hotel easily boasts of twenty-five hundred inhabitants, even when not working at full capacity. True, manufacturing, in one sense of the word, is not carried on but the preparation of food, the repairs and changes in the building, the moving of guests and baggage all entail the same degree of hazard, and accidents will occur.

The gigantic twentieth century hotel is a monument erected to public service and it has attained its maximum efficiency on the North American continent. To date, competition has been responsible for innumerable devices calculated to make well guests comfortable and happy, but far too little stress has been placed upon the necessity for this comfort and homelike touch for those who suddenly become ill. To be confined to bed at home is bad enough and there is no more dreary an occupation than that of watching the hands of the clock as they indicate the passing of the night. How much more terrible for a traveler away from home—sick, disheartened and disgruntled—waiting for the dawn which will bring no friend nor relative but just strangers to wait upon him for a gratuity. With the idea of remedying this defect in the modern hotel, the United Hotels Company has established in The Roosevelt, New York, N. Y., which was recently opened, a miniature hospital, small, compact, but nevertheless complete, and so arranged and installed that a maximum amount of service can be given those guests who require the use of its facilities.



Floor plan of hospital suite.

The Homeliness of the Suite

Four ordinary-sized hotel rooms were utilized in building this hospital. The first was made into a double room and was turned over to two of the nurses for their quarters; a double-door separating this room from the consulting room not only gives the doctor privacy but permits a nurse while off duty to enjoy a few minutes of quietude. The telephones in the nurses' room are installed without bell boxes. During the night, with the communicating doors open, the ring of calls for the nurses can easily be heard.

The second room, besides having been made into a consultation room, also has a laboratory and a wash-room. The consultation room has been made inviting and looks more like one's own library than a doctor's office. The same Colonial style of furnishing which typifies The Roosevelt finds its place in this room where no diplomas nor medical certificates decorate the walls. One notices soon the absence of file cabinets and there are no medical paraphernalia or instruments on view. The laboratory has been so constructed as to obtain the maximum amount of working and storage space. Here one finds the filing cabinet and alongside it a working table with ebony-finish, acid-proof top and the drawers of proper size to hold pipettes, test tubes and other laboratory material. A burette stand with two burettes is easily kept in a compartment so as to be available and safe from breakage at all times. Two shelves above these two pieces house large reagent bottles, tripods and specimen jars, and milk-white glass panelled doors keep these from view. Over the alborine sink and drain-board there is a shelf with an electric incubator, and space enough to keep a large supply of flasks. The basin is fitted into a niche in the wall and underneath it and out of the way is the electric centrifuge. Covering the wall above the sink and up to the shelves are racks for reagent bottles and a housing for the blood-urea aeration outfit, as well as pegs for test tubes, flasks and the like. These have all been screwed to wooden backs and the entire contrivance treated with the aniline acid-proofing.

Reception Room Attractively Decorated

The reception room, while not very large, is enlivened by the gay colors of French wicker furniture and here again the wall space has been utilized with a view to beauty rather than for the posting of innumerable certificates.

The operating room boasts of a battery of steam sterilizers of exceptional quality mounted on brackets and supported by steel plates which have been incorporated in the walls. The autoclave is large enough to take care of two drums of the size used in every large hospital. The

excess steam is utilized to make distilled water and by combining the effect of check valves set at twenty-two pounds and blow-off valves set at twenty-four pounds the entire apparatus is able to sterilize without steam hissing noisily into the room. The instrument cabinet is built into the wall and will not suffer from the footmarks that so frequently mar the ordinary style of cabinet. The operating table, wall stand and instrument table are of the latest type and monel metal has been used wherever possible. An extra large door permits easy passage of the stretcher from this room into the next, which is the employees' waiting room and which is only a few feet from the service elevator. The operating room is not for the exclusive use of the house physician, but a limited visiting staff is permitted to send in patients to register as guests and to be treated in the hotel. This arrangement is subject to the consent of the house physician and he exercises control over the patient while in the hotel.

How cheerful convalescence is offered to the patients at Hotel Roosevelt. The roof is easily reached by means of the service elevator and sunlight plays without interference on the occupant of the wheel-chair.

The employees' room has been divided by steel partitions into an attractive room where they can await their turn to be treated, and into two clinic rooms. Even here, the same gay-colored wicker furniture has been used and its effectiveness is heightened by contrast with the hospital-like white steel furniture and appliances. An idea of the beauty of this, a more generally neglected department, that is, neglected from the standpoint of beauty—is obtained from the accompanying illustration which also shows a part of the table in one of the treatment rooms, the door having been held open. One dressing room is for minor injuries and for head treatments, while the other, with a small-sized operating table and a baking oven, takes care of appropriate cases.

A wash-basin and an electric sterilizer save foot-steps and preclude the use of the operating room for any purpose other than for major operations. These rooms measure only eight feet, six inches by five feet, six inches but the type of equipment in each is so distinctive and so placed that treatments are being given without the feeling of restricted space. A large supply closet is also entered from the employees' waiting room.

The floor plan shows that the operating room need not be used as a passageway from the doctor's office to the employees' treatment rooms, and how a large electric exhaust fan, placed in the space over the built-in instrument cabinet, can clear the operating room of ether vapor and thus prevent it from reaching the main corridor.

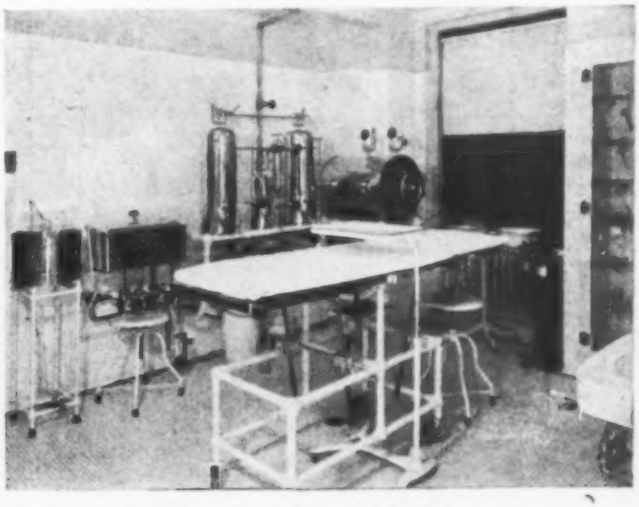
Convenience of Location

The suite is situated on the third floor, making it very convenient for the employees whose dormitories are on the floor below, and for the doctor's own patients who have not far to go from the main lobby. The Turkish bath is also close by and patients can be moved in either direction without much exposure or loss of time. Proper lighting was for a long time considered only possible near the roof. Equipped with four powerful ceiling lights each modified by milk-glass globes, and situated slightly beyond the limits of the table, no defect in illumination is apparent. In addition, there is a portable condenser and wall outlets which have been installed with no idea of economy. Placed waist-high, they not only save the nurses' backs and prevent short-circuits when the floor is washed but they actually forestall stumbling over loose floor wires, so often the cause of accidents in darkened operating rooms.

Besides the resident physician and his assistant, three nurses are employed in this department, two being on duty eight hours, beginning at eight in the morning and relieving each other at four, and a third coming on duty at nine, until half-past six, making a total of eight hours. In this way the hospital is never without the services of a graduate nurse.

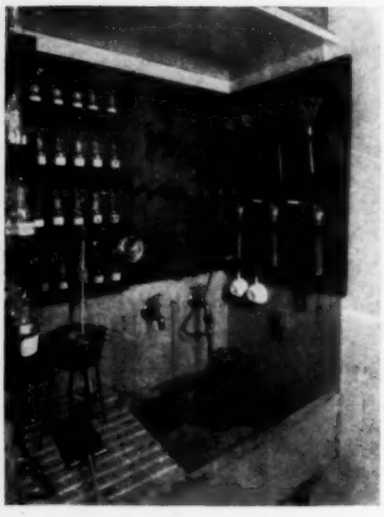
The nurses give various room treatments, attend to a portion of the clerical work, do first-aid and other dressings, and supervise the dietary of sick employees. The nurse in charge, as an additional duty, visits all sick rooms every morning, whether the guest is without medical attention or not, and whether an outside doctor is employed. She suggests how the various appliances can be obtained, assists the special nurse (if any)

A corner of the service waiting room.



A view of the operating room.

in getting whatever the patient needs and advises the proper departments of the hotel of the occurrence of sickness in that particular room. This not only gives the patient the best kind of service but adds the touch of home to his treatment which is so utterly lacking in many other establishments. Without these daily rounds, guests would not be advised of the stock of urinals, bedpans, hot water bags, etc., which are for loan, free of charge, when needed, nor would it be possible to have these articles returned; and properly sterilized when the patient is no longer in need of them.



A view of the laboratory of the hospital suite, Hotel Roosevelt, New York, N. Y. In the upper right hand corner can be seen the bottom of the incubator, below, out of sight, the centrifuge. The space above the sink measures one yard across, twenty-one inches deep and thirty inches high.

Charts such as have been approved by the American College of Surgeons are used exclusively, and histories are typewritten and preserved in the files for future reference.

Already the comments of the guests indicate that the establishment of this miniature hospital is needed and welcome, and that it meets with their approval. It is our opinion that, properly managed, such a suite can be successfully operated and can minister to the sick without the odors of chemicals reaching the corridors and taxing the sensibilities of the fastidious.

GUY'S HOSPITAL TO CELEBRATE BI-CENTENARY

Guy's Hospital, London, will celebrate its bi-centenary, January 6, 1925, also the date the medical school will celebrate its centenary. The hospital was founded January 6, 1725, "at the sole costs and charges of Thomas Guy Esquire," for the reception of 400 sick persons or upwards laboring under any distempers, infirmities or disorders thought capable of relief by physick or surgery." An attempt is to be made during the coming year to relieve the hospital and medical school of their indebtedness.

HOSPITAL LIBRARIES ROUND TABLE TO BE HELD IN CHICAGO JANUARY 3

The winter meeting of the Hospital Libraries Round Table will be held at the Hotel Sherman, Chicago, January 3, at 2:30 p. m. The meeting will be given over to two papers and a round-table discussion. The papers scheduled are: "Dovetailing Medical Social and Hospital Library Work," by Miss Helen Beckley, medical social worker, Michael Reese Hospital, Chicago, Ill., and "Why Include Hospital Service in Public Library Activities," by C. W. Sumner, Sioux City, Iowa.

The following topics will be discussed at the round-table conference: Points to be investigated, by Miss Margaret Hickman, librarian, public library, Rochester, Minn.; Comparative costs of hospital library work with other departments of the public library, by Miss Lila Bowen, Hospital Librarian, Public Library, Omaha, Neb.; What of books for the nurses and interns, by Miss E. B. Bailey, Hospital Librarian, Public Library, Minneapolis, Minn.; Administration of the United Hospital Library as distinguished from the group hospital library, by Mrs. G. H. Birdsall, Hospital Librarian, Lakeside Hospital, Cleveland, Ohio; Outside wedges, by Miss Rose A. O'Connor, hospital librarian, Public Library, Sioux City, Iowa; The new course for hospital librarians as worked out at the University of Minnesota, Minneapolis, and hospital library publicity; a demonstration of the Brayco picture projector, by Miss Helen Seymour, American Library Association, headquarters, Chicago, Ill.

BROOKLYN HAS MEDICAL PRESS REFERENCE COMMITTEE

A press reference committee has recently been formed in Brooklyn, N. Y., to act as a central fixed agency to which the press may turn for information and advice on medical news items. The movement is an expression of cooperation on the part of the daily papers of Brooklyn with the King's County Medical Society, and the formation of the committee was brought about through the efforts of Dr. Charles A. Gordon, president of the society with a number of newspaper leaders of the city.

The committee is composed of representatives of each branch of medicine with whom the Brooklyn papers may communicate through the offices of the county medical society. The organization of the committee will not be an attempt to control medical news in the public press but rather represents an effort to establish an entente in order to furnish to the press authoritative medical information and advice in a practicable form.

Although the entente is just an experiment it is a step forward for both the medical profession and the press.

FORM AMERICAN BOARD OF OTOLARYNGOLOGY

The American Board of Otolaryngology, composed of representatives of the five national otolaryngologic associations, was organized in Chicago, Ill., November 10. The following persons constitute the board of directors: Drs. Harris P. Mosher, Boston, president; Frank R. Spencer, Boulder, Colo., vice president; Hanau W. Loeb, St. Louis, secretary and treasurer; Thomas E. Carmody, Denver; Joseph C. Beck, Chicago; Thomas H. Halsted, Syracuse, N. Y.; Robert C. Lynch, New Orleans; Burt R. Shurley, Detroit; Ross H. Skillern, Philadelphia; William P. Wherry, Omaha. The office of the board is at 1402 South Grand Boulevard, St. Louis, Missouri.

The purpose of the association is to elevate the standard of otolaryngology, to familiarize the public with its aims and ideals, to protect the public against unqualified practitioners, to receive application for examination in otolaryngology, to conduct examinations of such applicants to issue certificates of qualification in otolaryngology and to perform such duties as will advance the cause of otolaryngology. The first examination will be held at the time of the meeting of the American Medical Association.

Man is fallen; nature is erect, and serves as a differential thermometer, detecting the presence or absence of the divine sentiment in man. By fault of our dullness and selfishness, we are looking up to nature, but when we are convalescent, nature will look up to us.—*Emerson.*

RECENT HOSPITAL DECISIONS

By DOROTHY KETCHAM, Ann Arbor, Mich.

Malpractice Charged Against Health Center

The following cases came up recently before the Supreme Court of California which denied a rehearing, from the District Court of Appeals. In general, the cases follow similar holdings, bearing on charitable and governmental institutions. So far as we governmental institutions. So far as we know, however, this is the first time that malpractice has been charged against a university health service.

The action was brought to recover damages for personal injuries which are said to have resulted from the negligence of the physician in charge of the infirmary at the University of California at Berkeley. The demurrer stated this to be a state agency in charge of a governmental function, the infirmary being maintained as a part of the educational institution, consequently not liable for the torts of its agents in the operation thereof.

The student in attendance at the university paid the required fee of $3 semi-annually, thereby becoming entitled to consultation,. medical and hospital care at the infirmary. The details of the various recitals will not be enumerated. It seems that with the payment of an additional amount the patient's tonsils were to be removed. It is charged that careless methods were used in the operation resulting in a dislocation of the jawbone and a fractured vertebra in the neck. Damages are claimed.

One of the questions raised is whether the infirmary is a department of the university, educational and public in character, or whether it is private and proprietary. The board of regents have in reality two activities: "when acting in a private capacity, its liabilities arising out of either contract or tort are the same as those of natural persons or private corporations . . . In its governmental or public character, the corporation is made by the state one of its instruments or the local depository of certain limited and prescribed political powers, to be exercised for the public good. But in its proprietary or private character the theory is that the powers are supposed not to be conferred primarily or chiefly from considerations connected with the government of the state at large, but rather for the private advantage of the compact community which is incorporated as a distinct legal entity or corporate individual; and as to such powers and to property acquired thereunder and contracts made with reference thereto, the corporation is to be regarded as private in character.—*Dillon on Municipal Corporations (5th ed.) Sec. 109.*"

"Suffice it to say that they (the states) generally hold that the maintenance of a hospital by a municipality is a governmental function and in the conduct thereof the municipality is not liable for the tortious acts of its employees . . . It conclusively appears that the infirmary in question is conducted by the defendant corporation for the exclusive use of the students; and that it is so conducted for the sole purpose of safeguarding and protecting the health of the student body. This being so, it is in no sense an organization for profit, and the imposition of the small fee does not convert this governmental function into a proprietary one . . . This being so, the promotion and welfare of the students in this respect must be held to be the exercise of a duty involving governmental functions in the highest degree."—*Davie v. Board of Regents, University of California, 227, Pac. 243.*

Included in Property Exemption

The Supreme Court of Kansas May 10, 1924, held that the exemption of property of the educational or charitable institutions which is provided for in the constitution and statutes, refers only to institutions of Kansas, and not those of another state. Although not directly involving a hospital, the legal status of the institutions is the same. *Morgan v. Atchison T. X. S. F. Ry. 225 Pac. 1029.*

Free Services of Employes Not Required

According to a recent decision of the Supreme Court of Illinois (April 14, 1924) the employees of a charitable institution are not compelled to perform free services in order that the institution may be charitable. The question was whether property used by the church for the payment of salaries (the janitor, the organist) etc., was exempt from taxation.—*Yates v. Board of Review, 144, N. E. 1.*

Entitled to Habeas Corpus Writ

The folowing situation came before the Court of Appeals of New York June 6, 1924. A patient was committed under the insanity law to the hospital, as insane, apparently. The hospital authorities made a thorough examination and found him to be insane. The court points out: "It was the duty of the hospital authorities, upon examining Ledwith, to discharge him immediately if they believed him to be sane. It was likewise their duty if they determined that he was insane to take the necessary steps provided by other provisions of the insanity law to have him committed to the proper institution for the treatment of the mental disorder . . . No such proceedings were taken. Ledwith, apparently, was held for the balance of the thirty days, although no other examination was necessary." Under the circumstances, the court decided that he was entitled to a writ of habeas corpus.—*People v. Board of Trustees of Bellevue and Allied Hospitals, 144, N. E., 657.*

Agents of University Liable for Negligence

The following case which was refused a rehearing at the same time (June 23, 1924) by the supreme court and which came also from the district court of appeals, points out that the immunity which the state university has from liability for the negligence of its servants and agents in the infirmary does not extend to and cover the negligent servant acting as its agent. The principle which protects the regents cannot be applied to the agent (Legge). "Where wrongs are done to individuals by those who are the servants of the government those injured are not remediless, as such servants or other employees may be sued the same as other persons for torts which they have committed."—*Davis v. Regents of University of California, 227, Pac. 247.*

DECATUR AND MACON COUNTY HOSPITAL PUBLISHES "HOSPITALER"

The Hospitaler is the name of the new bulletin of the Decatur and Macon County Hospital, Decatur, Ill., of which Dr. Paul W. Wipperman is superintendent. The house organ made its first appearance with the December issue and will be published each month in the interests of patients and everyone connected with the hospital. The front page of the December issue carries a romantic story of the hospitaler of the eleventh century and links the hospital idea then with that of today.

A PRACTICAL ANNUAL REPORT FOR INDIVIDUAL STAFF MEMBERS

By ZULA MORRIS, Record Librarian, Butterworth Hospital, Grand Rapids, Mich.

IN A discussion of record forms for 1923, the superintendent of Butterworth Hospital suggested that a form be prepared which would show at a glance the volume and the character of each staff man's work. He thought it possible to devise an analysis that would be easily understandable, even by the layman, and declared such an analysis indispensable to a proper evaluation, on the part of the board of trustees, of the professional service of staff members.

The working out of this suggestion resulted in the printing of a form on loose leaf sheets, the accumulation of which we call our "doctors' book." The form follows quite closely the *Analysis of Hospital Service* in use in most hospitals for compilation of monthly reports. It was felt that the information it contains should be available immediately in the case of every staff member and would be detailed and specific enough for just appraisement of his work.

Each day, before records are filed, the data indicated in the form are transferred from the summary card (which also corresponds to the monthly report form) to the doctor's book. At the end of the month *each* doctor's sheet is totaled to secure the result of his monthly performance and *all* the doctors' sheets are totaled to make the monthly report. The form used in our department, is here shown.

As time went on, we discovered new uses for the sheets of our doctors' book. We adopted the custom of recording from day to day on one of these sheets (marked *Deaths for February*, for instance) all cases of death. At the end of the month this summary of deaths (doctors' names in margin) was very convenient for staff discussion. It formed a much more intelligible basis for such consideration than the briefer monthly report form, since it showed just what diagnostic work had been done on each case, such as x-rays, laboratory analyses, autopsies, consultations.

Gradually the physicians themselves became interested and would ask to see "my sheet in the doctors' book." In this interest on the part of staff members originated the idea of sending each physician a summary of his work for the year. The form of this annual statement, shown below, of course corresponds closely to that of the doctors' book.

The doctors' book sheet and the annual report are capable of adaptation to many uses. Concretely, an instance of this sort might occur. A member of the junior staff applies for membership on the senior surgical staff. A study of the annual report may reveal the fact that his work is about equally divided between several departments, being listed as Obstetrics 48, Ear, Nose and Throat 40, General Surgery 45. A further examination of the applicant's work, as recorded by individual cases in the

BUTTERWORTH HOSPITAL
Grand Rapids, Mich.

January, 1924.

My dear Doctor Courtland: :
The following statement is a resume of your work in Butterworth Hospital for the year 1923:

Total No. Cases	Percentage of Deaths	Eye	Gynecology	Medicine	Obstetrics	Ear, Nose & Throat	Pediatrics	Surgery
161	*8.08*	...	*27*	*26*	*11*	...	...	*97*
Cured	Improved	Unimp.	Diagnosis Only	Death Within 48 Hours	Death Institutional	Labor	Newborn	Stillborn
14	*119*	*6*	*3*	*6*	*5*	*4*	*2*	*2*
Operation	Infection	Laborat'y Reports	X-Ray Reports	Consultations Obtained	Consultations Given	Autopsy	Laborat'y & Clinical Diagnosis Disagree	Provision'l & Final Diagnosis Disagree
124	*4*	*165*	*49*	*11*	*6*	*1*	*2*	*6*

We hope that this tabulation, which we shall issue from time to time, may prove of service to you as well as to Butterworth Hospital. Therefore we invite your suggestions as to compilation of additional statistics that might be of value to you.
Thanking you for your co-operation during the past year, I am,
Yours very truly,

JOHN DOE,
Superintendent.

Courtland, Dr. R. E.

Consultation given on case.		3782	3843	3920	4030	4064	4203																								
Date	Diagnosis.	History Number.	Cured.	Improved.	Unimp.	Diagnosis Only.	Death Institutional.	Death within 48 Hrs.	Labor.	Newborn.	Stillborn.	Operation.	Death Operative.	Infection.	Laboratory Reports.	X-Ray Reports.	Consultations.	Autopsy.	Laborat'y & Clinical Diagnosis Disagree.	Provisional and Final Diagnosis Disagree.	Service Case.	Eye.	Ear, Nose & Throat.	Gynecology.	Medicine.	Obstetrics.	Pediatrics.	Surgery.	Diagnosis.		
12- 8-23	Appendicitis, chronic..	76	..	1	.	..	..	.	.	.	.	1	.	.	2	.	.	.	.	.	.	.	.	.	.	.	.	1	.		
12- 5-23	Appendicitis, acute....	74	..	1	.	..	..	.	.	.	.	1	.	.	2	.	.	.	.	.	.	.	.	.	.	.	.	1	.		
12- 8-23	Goitre	3	..	1	.	..	..	.	.	.	.	1	.	.	.	.	.	.	.	.	.	.	.	.	.	.	.	1	.		
12-12-23	Myocarditis, chronic...	6	..	1	.	..	..	.	.	.	.	.	.	.	1	.	.	.	.	.	.	.	.	.	1	.	.	.	.		
12-13-23	Inguinal hernia	54	..	1	.	..	..	.	.	.	.	1	.	.	.	.	.	.	.	.	.	.	.	.	.	.	.	1	.		
12-16-23	Inguinal hernia.....	56	..	1	.	..	..	.	.	.	.	1	.	.	3	.	.	.	.	.	.	.	.	.	.	.	.	1	.		
12-17-23	Abscess, pelvic.....	1	..	1	.	..	..	.	.	.	.	1	.	.	.	.	.	.	.	.	.	.	.	.	.	.	.	1	.		
12-18-23	Exophthalmic goitre...	1	..	1	.	..	..	.	.	.	.	2	.	.	.	.	.	.	.	.	.	.	.	.	.	.	.	1	.		
12-26-23	Abortion	49	1	1	.	..	..	.	.	.	.	1	.	S.	1	.	.	.	.	.	.	.	.	.	.	1	.	.	.		
12-20-23	Fibroma of uterus....	56	..	1	.	..	..	.	.	.	.	2	.	.	4	.	.	.	.	.	.	.	.	.	1	.	.	.	.		
	Total for December...	10	1	9	.	..	..	.	.	.	.	11	.	1	16	.	.	.	.	.	.	.	.	.	1	1	1	.	7	.		
	Total for year—1923..	161	14	119	7	3	5	6	4	2	2	124	.	4	165	49	11	1	2	6	.	.	.	27	26	11	.	97	.		

doctors' book, may show that twenty of the cases listed under general surgery involved only minor operations, such as suturing of wounds, application of casts, drainage of abscesses. Such definite analysis will enable the board of trustees to determine quite accurately the candidate's fitness for the staff position for which he is applying.

Slightly different information may be required in hospitals of a different type from the one in which these forms were developed. But it would seem that a statistical tabulation of somewhat similar character would be of value in almost any kind of hospital.

HOSPITALS OF CALIFORNIA HOLD FOURTH ANNUAL CONFERENCE

Several hundred delegates from the hospitals of California attended the fourth annual conference of the hospitals of California held under the auspices of the League for the Conservation of Public Health, at Virginia Hotel, Long Beach, November 6, 7, 8, 1924.

One of the outstanding features of the meeting was the report of the committee on hospital costs which has been investigating the subject during the past year. The committee chiefly concerned itself with gathering data on every phase of hospital costs and medical care to determine whether hospital service can be rendered more economically to people of moderate means. The report showed that hospital costs are increasing, despite the best efforts of medical and hospital economists to decrease them by constantly improving methods in purchasing, managing and economizing in all departments of hospital administration. But it brought out that the efforts to economize and reduce costs are more than offset by the increasing cost of services which are demanded from the hospitals the same as from hotels. The entire session Friday morning was devoted to the report and discussion of this subject.

The war against the quackery which prevails in the state was evident in the speeches and discussions of the meeting. In response to the address of welcome, Dr. Dudley Smith, president, League of Conservation of Public Health, Oakland, said in part: "The people of a community are entitled to expect that a true hospital will not risk the health and lives of its patients by allowing quacks or unqualified persons to treat them . . . The menace of quackery is increased immeasurably when quackery is admitted to hospitals—the citadels of scientific medicine."

Other addresses of the opening session were "Some Problems Confronting Hospitals as Agencies of Scientific Medicine," by Dr. Percy T. Magan, White Memorial Hospital, Los Angeles; and "Problems Confronting Scientific Medicine and the Hospitals' Responsibility in Their Solution," by Dr. D. Granville MacGowan, president, California Medical Association, Los Angeles.

The general meeting November 8, was given over to discussions on various timely topics. A general discussion was held on nursing education—What should be taught, by whom, where, under whose jurisdiction and for how long. Lines of essential contacts between the school of nursing and the hospital. Shall California have more than one class of nurses? Some of the other topics discussed were "Practical Methods of Coordinating the Service of Hospital, Physicians, Nurses, Medical Social Workers and other Health Agencies to Insure Better Health Work for the Public"; and "What Should be Quoted in the Room or Bed Rates in Hospitals and What Should be Charged as Legitimate Extras?"

Informal group luncheons were held during the first two days of the conference at the Virginia Hotel to provide opportunity for the discussion of hospital work by hospital staffs, roentgenologists, nurses, medical social service workers, dietitians, laboratory technicians, accountants, officials of municipal, county and state hospitals and the members of the local committee on arrangements.

The morning session, November 7, was devoted to visiting hospitals in Los Angeles county.

The constructive program of the League for the Conservation of Public Health is as follows: To promote and maintain more and better hospitals wherein educated physicians may render better service to every citizen of every community of California; to counteract pernicious propaganda by presenting to the public reliable information, through *Better Health Service* and other proper channels of publicity.

FEDERAL BOARD OF HOSPITALIZATION FORMED

A federal board of hospitalization has recently been formed for the purpose of coordinating the hospitalization of activities of the medical department of the army, navy, the bureau of medicine and surgery of the navy and the public health service, St. Elizabeth's Hospital, the National Home for Disabled Volunteer Soldiers, the office of the commissioner of Indian Affairs, and the U. S. Veterans' Bureau.

The members of the board are Brig-Gen. Frank T. Hines, director, U. S. Veterans' Bureau, chairman; the Surgeon General of the Army; the Surgeon General of the Navy; the Surgeon General of the Public Health Service; the superintendent of St. Elizabeth's Hospital; the president, board of managers, National Home for Disabled Volunteer Soldiers, and the commissioner of Indian affairs.

The chief functions of the board will be to effect proper coordination in all government hospitalization activities to increase efficiency and service and promote economy in operation and maintenance. The board will also act in an advisory capacity to the president in matters pertaining to hospitalization.

PUBLISH SOCIAL WELFARE ADMINISTRATION

Social Welfare Administration is the name of a new bi-monthly magazine issued by the publishers of Better Times, the organ of the New York charitable and social work. The new publication is devoted to the administrative problems of executives and directors of charitable organizations, welfare institutions, and other social agencies throughout the United States and Canada. The magazine is the successor of the section of Better Times which was known as Money Raising and Administrative Methods.

CORRECTION

In describing the Buffalo convention exhibit of the Hospital Library and Service Bureau in our November issue, page 465, it was stated that the bureau had 200 packages. This was the number displayed and not the number the bureau has available. The library and service bureau has a total of 1,300 package libraries.

DR. FISHBEIN MADE EDITOR OF A. M. A.

Dr. Maurice Fishbein, Chicago, Ill., has been appointed editor of the *Journal of the American Medical Association*, to succeed Dr. George H. Simmons who has retired.

THE INFORMATION DESK

No satisfactory solution to a problem in your hospital is too trivial to pass on to other workers in the field. No question that perplexes you is too small to bring to the attention of those with greater experience in the field. This department is the readers' exchange, and its usefulness is dependent upon the measure in which its readers share their problems and their discoveries.

REMOVING WASTE AND GASES FROM HOSPITAL LABORATORIES

Those who are interested in the construction of hospitals have to face the problem of providing a satisfactory means of removing the corrosive wastes and gases from the laboratory without damaging the main drainage and ventilating systems.

The solution of this problem requires the use of a material which should have the following characteristics:

(1) Be proof against corrosion; (2) be readily secured; (3) be easily installed by ordinary means; (4) have sufficient structural strength; (5) offer possibility of maintaining tight joints.

For this use, four materials are commercially available, cast iron, wrought iron, tile and ferrosilicon alloy. Of these cast iron and wrought iron will fulfill all except the first requirement, wrought iron being even more subject to attack by acids than is cast iron.

Tile fulfills the first requirement until its glaze is destroyed but is structurally weak and offers the further objection that it is almost impossible to make joints so that they will not leak. This is the reason that most city plumbing codes prohibit the use of tile inside the walls of a building.

Ferrosilicon alloy of the proper analysis is proof against the worst corrosive conditions ever found in a laboratory. It is installed just like cast iron pipe by means of leaded joints which may be expected to remain permanently tight. It has ample strength and will outlast the building.

The same material is most suitable for fans to remove the corrosive fumes from the hoods in the laboratory; also for sinks, sink outlets and traps.

As a result of providing against corrosion in the waste lines, and for the safe removal of noxious fumes, the laboratory may be placed in any location in the building to permit its proper relation to other hospital services.

REQUISITES FOR MEDICAL HISTORIAN AND FILE CLERK

A reader has inquired as to the qualifications for a medical historian and file clerk. A good foundation for a medical historian or a file clerk is (1) training in hospital routine obtained either by nursing or by clerical work in the business office; (2) business experience or library training in filing; (3) familiarity with medical terminology or with languages that form its basis.

Added to this training, the qualities of accuracy in details and general intelligence are essential to success in work of this nature.

In hospitals of eighty-five to 125 beds salaries for medical historians range from $75 to $150 a month. Often complete maintenance is given in addition to salary.

A DURABLE WINDOW SHADE FABRIC

A new kind of window shade fabric formed of material with a woven cotton base and a pyroxylin finish is now being widely used by hotels, office buildings, hospitals, schools and other institutions. The application of this pyroxylin coated material to window shades was perfected after considerable research by chemists who thoroughly investigated the problems of developing the fabric and the use to which it would be put, and the conditions affecting it when in use.

The material was developed at the request of business men who wanted a fabric which was better adapted to actual service conditions than the ordinary shade cloth. They found that when shades became ruined by rain, the carelessness of leaving the window opened was condemned, and not the fabric from which the shades were made. The same thing happened when shades became faded by sunlight. The idea was to develop a material which when it became soiled could be cleaned and renovated, instead of being replaced. The new fabric, when soiled through use or exposure, can be renovated by scrubbing with soap and water. It has been specially constructed and treated chemically so that it will not crack or sag, thus avoiding two of the main reasons for the replacements of ordinary shades at frequent intervals.

LIBRARIES IN CONTAGIOUS HOSPITALS

Inquiry is occasionally made as to the advisability of conducting a general library in contagious hospitals. Executives of such hospitals agree that it is better to provide patients in these hospitals with newspapers and magazines and provide children with pictures and other inexpensive forms of reading matter which can easily be destroyed when the patients leave. However, a small library can be maintained in a convalescent ward where the books are used by convalescent patients.

Those who are enamoured of practice without science are like a pilot who goes into a ship without rudder or compass, and never has any certainty where he is going." —*Leonardo Da Vinci.*

NURSING AND THE HOSPITAL

Conducted by CAROLYN E. GRAY, R.N.,
71 Willow Street.,
Brooklyn, N. Y.

THE INFLUENCE OF THE UNIVERSITY IN MODERN NURSING EDUCATION

THERE is very general agreement that sick people should have nursing care, and that this care should be in proportion to their need, and should not be dependent upon their ability to pay for it. There is abundant evidence that this idea is not new. For many centuries it has been the dominant motive actuating those who founded hospitals and those who served in them. There is equal evidence that it has never been easy to live up to this ideal, and of late years the difficulties seem to have increased.

The history of hospitals shows very clearly that in their beginnings they were places of refuge for the poor and the sick, and this continued until quite recent times. Certainly the beginnings of all the old, well-established hospitals in this country show that the "sick poor" were their chief concern. Today this condition is entirely different. We find not only the sick poor but all classes of people depending upon the hospitals. All of the influences that operate to bring people together in large cities, and necessitate their living under crowded conditions tend to increase the burden of work put upon the hospitals. Recently a real-estate circular came to my desk which stated that 49 per cent of the people in what has been a city of separate homes, are now living in apartments, and when buildings under construction are completed 51 per cent will live in apartments. One might add *small apartments* at that!

Growing Need for Hospital Services

It is a foregone conclusion that the great majority of apartment house dwellers will seek hospital care in time of illness and many who live in the most comfortable and palatial homes do likewise, because it is only in the hospitals that facilities for the modern, scientific care of all types of cases can be found. Consequently, during the last fifty years hospitals have changed from refuges for the "sick poor" to institutions which all classes in the community look to for service, and to the credit of the hospitals be it said they have responded to the increased demands in a praiseworthy way.

But the effort to do so has entailed many changes. One most pertinent to our problem is the rapid turn-over of cases. In almost every community the number of hospital beds available is less than the number actually needed and the long list of patients waiting for admission makes it necessary to get the patients already occupying beds in condition to be discharged as promptly as possible. This means a speeding up of work that has changed the atmosphere of hospitals decidedly and is responsible for a feeling of tension of which both the patients as well as the workers are conscious.

Another important factor is the adoption of so-called aseptic technic in all departments of the hospital. Twenty-five years ago our knowledge of bacteriology was limited. The precautions taken then, to prevent the spread of infection would be considered clumsy and inadequate today. It was customary to erect separate buildings for such communicable diseases as scarlet fever, measles, diphtheria, etc. "Isolating a patient" then meant putting him in a separate room, or a separate building quite alone, or only with patients suffering from the same disease.

"Isolating a patient" now means a totally different thing. A hospital ward with which I am fairly familiar recently housed a group of patients whose diagnoses were as follows:—scarlet fever, measles, typhoid, whooping cough, gonorrhea, ophthalmia, and diphtheria. Yet all of these patients were isolated, and according to our modern standards the isolation was more effective than formerly. These patients were in separate cubicles with individual equipment and the nurses were depended upon to prevent cross-infection by practicing a whole group of precautions that are extremely time-consuming. But it is not in the case of communicable diseases only that these precautions are observed. Acting on the principle of "safety first" these time-consuming procedures which are generally spoken of as "individual precautions" or "aseptic technic" are observed in practically every department of the hospital. No one who has not actually put these precautions into practice has any idea how enormously they add to the volume of necessary work.

The increased number of sick people seeking hospital care, the rapid turn-over of cases, and the almost universal observance of aseptic precautions have resulted in a decided increase in the volume of work required. Coupled with these conditions have been the rapid multiplication of hospitals and the increased number of hospital beds.* To find a hospital that has not outgrown its quarters and is not seeking to increase its bed capacity would be as difficult a task as to find the proverbial needle in a haystack. All of these conditions effect the amount and kind of nursing care required as well as the number of people

*Between 1890 and 1900—400 hospitals were erected. Between 1900 and 1910—700 hospitals were erected. Between 1910 and 1920—600 hospitals were erected.
These were hospitals large enough to maintain schools of nursing, and the number does not include many with a bed capacity less than 50.

necessary to give such care at all times.

For many centuries various religious orders supplied the nursing service in all large hospitals, and still do so to a considerable extent. However, it is noteworthy that even in institutions owned and managed by religious orders, it has been necessary to supplement the number of sisters by student nurses. There are many evidences that even the religious orders are not finding it easy to keep their ranks filled.

During the last few years several of the first schools of nursing in this country have celebrated their fiftieth anniversary. At the time when these schools were started, there were practically only two openings for women, one was marriage and the other teaching. It is a matter of common knowledge that many capable women were not successful in securing either husbands, or teaching positions, and developed into "stay-at-home maiden aunts" who carried a heavy part of the family burdens and were counted upon for the numerous unclassified household tasks (including home nursing) that it is now so hard to find anyone to do.

To this group the early schools of nursing in this country made a definite appeal because the new profession of nursing opened up opportunities for independent careers. The response resulted in the enrollment of a type of student that is still looked back upon with envy. The hospitals benefitted by the services of this early group who built up a tradition of loyal service that we find it difficult to equal today. But it must be remembered that they were mature women. The majority were better educated than the high school graduates of today, they were adaptable, accustomed to carrying responsibility, skillful in the use of their hands, and usually clever housekeepers. No amount of earnest seeking discloses any such group that we can draw upon today.

It is becoming more and more the proper thing for a girl to prepare herself for a career just as a boy does. The maiden aunts of today are, according to our last census, found in any one of 643 gainful occupations. Regardless of what we may think of this change in the status of women, it is a fact we have to recognize and reckon with.

One other factor in the success of the early schools of nursing was the appeal of religion and self-sacrifice. This was all the more potent because the patients were the "sick poor," and the student nurses were made to feel that they were cooperating with the trustees in helping to make a worthy charity possible. Without question the hospitals still do a great deal of free work, but the business side is being emphasized to a greater extent than ever before.

Conflict of Ideals

In many hospitals the student lives in an atmosphere surcharged with evidences of wealth, costly private rooms, doctors' and surgeons' fees (which are not minimized in the telling), special nurses and extravagant outlays for flowers. Hospitals have found it possible to erect palatial buildings, to purchase the most expensive equipment and more and more they are finding it necessary to pay the market price for services rendered. Added to this the attitude of the patients even when they pay the smallest fees, or perchance are so-called free cases, is that they are entitled to the service rendered. There is a constant tendency on the part of the doctors as well as the patients to regard the student nurse as a *worker* and not a student.

The hospital environment created by the conditions mentioned makes it difficult to hold fast to the ethical standards we have treasured. Is it any wonder that schools of nursing are finding it impossible to capitalize religion and self-sacrifice as much as they formerly did?

Thirty years ago many teachers entered nursing schools. It was quite the proper thing to do, and the salaries paid nurses were higher than those paid teachers, but this is no longer true. About this same time the schools in the north and east benefitted by the enrollment of large numbers of Canadian and southern women. This source of supply is negligible now. The schools in Canada and in our own southern states have improved so markedly that there is no reason for either Canadians or southerners to leave their own sections. Then too, schools of nursing attracted many immigrants from England, Ireland, Scotland and the northern countries of Europe. These immigrants were a dependable type with a fundamental education that was thorough so far as it went and a courage that enabled them to surmount many difficulties. Today our immigrants are almost all from the southern part of Europe, from the Latin countries where nursing is regarded as fit work only for a religiouse or a Magdalene.

Main Supply from High Schools

All of these conditions tend to narrow our choice and schools of nursing are finding that their main source of supply is the high schools in the surrounding country. This means that high school girls compare nursing with 643 other occupations open to them and it is not always easy to convince them that the rewards in the nursing field, which to them seem intangible and remote, are equal to the allurements and quick returns in other fields.

Slowly and with many misgivings, schools of nursing reduced the entrance age from twenty-five years (forty years ago) to twenty-three, then twenty-one, then eighteen. There are still many faithful, conscientious principals of schools of nursing who do not believe eighteen year old are mature enough to be admitted to hospitals as student nurses. On the other hand, many recognize that a large proportion, in some instances as high as 75 per cent of the student nurses, are eighteen years or under, and this is the compelling reason for advocating a complete reorganization of the system of training which was intended for women of more mature years.

It is far from my purpose to minimize the value of the youth, enthusiasm and capacity for work of our student nurses, but they are constantly criticised for lack of appreciation of the value of human life, for failure to realize their responsibilities and for various other shortcomings which are part and parcel of their youth. On the other hand, one must concede that the patients must be safeguarded. So far as our present knowledge goes, the best way to safeguard the patients is to inculcate the highest ideals, to teach the student all we can that will vitalize and put meaning into the many necessary routine procedures; to provide close and sympathetic supervision by older women; to stabilize the nursing personnel by the addition of a group of permanent graduate nurses; to lessen the total night duty required, shorten the length of each term of night duty, and relieve them entirely from night duty in some departments. A study of the school of nursing in almost any large hospital shows that these changes are slowly and reluctantly being made. Reluctantly—not because of actual opposition, but because conditions are not understood even by many of the trustees of our hospitals, and these changes cost money in large enough amounts to make even the most generous wonder where it is coming from.

Despite the increased number of occupations open to women and the impossibility of securing an adequate

supply of student nurses to meet *all* the needs of *all* the hospitals, it is true that the enrollment in schools of nursing has been almost phenomenal. Witness these figures:

In 1893—70 schools of nursing in 13 states.

In 1923—1,800 registered schools of nursing in the U. S., Found in every state as well as in the Philippines, Hawaii, Porto Rico, and Cuba.

In 1893—500 graduate nurses.

Last census—150,000 graduate nurses who had met registration requirements.

Graduate approximately 15,000 nurses annually.

Need 20,000 new students annually to maintain present numbers.

Many students of these problems question whether we can reasonably expect to increase the enrollment of student nurses indefinitely and argue that because of the youth of the students, and the necessity for safeguarding the interests of the patients it will be necessary to have a permanent graduate staff supplemented by a student group. Even with this adjustment the total number of students required is very large, and it is pertinent to ask where they are coming from, and how are we to get them?

I have indicated that the high schools are our main source of supply. A careful reading of the report of the committee on nursing and nursing education published in 1923 by the Macmillan Company shows that such progress as has been made, has been in the face of innumerable handicaps. The educational values of nursing are greater than most of us appreciate, and if the handicaps are removed, and it is put on an educational basis comparable to teaching, domestic science, etc., it will continue to attract students. It is thought-provoking to study the enrollment in schools of nursing and in colleges for women. In the case of the latter, it is very evident that neither *high standards of admission, high standards of work required* during college years, *length of course*, nor *cost* has had a deterring effect.

Graduate and Student Service Compared

Someone may ask, is there no alternative except to conduct a school of nursing, and of course the answer is, graduate nurses. It has been the custom in almost all new hospitals to start with a group of graduate nurses and gradually diminish the number as the student body increased. Also, there are some private hospitals that are staffed entirely by graduates. Needless to say, a staff of graduate nurses is expensive and *not* always satisfactory. The cost is considered prohibitive and it is difficult to secure either a sufficient number, or a group whose methods of work are at all comparable. Graduate nurses do not take kindly to routine nursing work. Surprising as this may seem, it is the inevitable result of the military apprenticeship system which assigns the difficult and disagreeable tasks to the *new* students, and as the student progresses relieve her of these tasks so that they come to be considered *beneath* those who have advanced. Some schools of nursing have, in recent years, been trying to break away from this system, but even this is difficult and costly because the specialization of work in a hospital, just as in a workshop, makes it possible to increase the amount of work exacted of each worker. This is especially true in times of stress, or in hospitals that limit the number of nurses to the minimum. It is one way of stressing quantity and *not* quality of work, and nurses, like our men in the army during the recent war, become skillful in "getting by."

One of the points emphasized in the report of the committee of nursing and nursing education is that the *patient should be considered an entity* and that students should have a number of patients to care for, rather than a repetition of the same tasks for a number of patients.

Education, Not Rule-of-Thumb Training

The attitude of many graduate nurses toward routine work, and the variety of methods they employ, plus their difficulties in adapting themselves to new methods, constitute one of the strongest arguments for education not rule-of-thumb training. Even if all these difficulties were removed and it were possible to secure a sufficient number of graduate nurses who measured up to all our requirements and were *cheap*, I question whether an entire graduate staff would ever be as satisfactory as a personnel made up of graduates and students. The graduate group stabilizes the service and minimizes the results of the rotation of students but, on the other hand, the students stimulate the graduates, tend to keep them alert and alive, and offset the ever-present tendency toward becoming "stale-mates."

In the case of hospitals that decide to conduct schools of nursing, what problems and responsibilities have to be met?

First and foremost I should put a recognition of the fact that the students must be taught nursing and that nursing education, like all other education, costs. The payment is as inevitable as that night follows day. But this payment may be either *immediate* or *deferred*. By *immediate payment* I mean to educate the nurse to meet the needs of the community which in many instances are bigger, broader and more inclusive than the needs of any one hospital. All too frequently hospitals measure the education given the student nurse by the work they need to have done. They assume that the needs of the hospital and the needs of the community are similar. This is an utter fallacy. Witness the hospitals that are predominantly surgical and that stress such training at the expense of training in the care of children, mental and nervous cases, tuberculosis, venereal and communicable diseases. The public gullibly assumes that any graduate nurse knows how to care for such cases, and yet thousands of nurses never see such cases until they have finished their training.

The Need for Well-Rounded Training

If, perchance, the nurse who has never seen a case of scarlet fever is called to care for a child suffering from this disease (possibly one loved by the reader), think you she can render the kind of service you would want? Isn't it true that she learns at the expense of the child? The pity is that so often deferred payment is at the expense of little children! For everything that the school fails to give a nurse while she is in training, her future patients pay, and oftentimes the price paid is far in excess of what it would have cost the school if the price in terms of adequate training had been paid immediately. Much has been said about the exploitation of student nurses. I would like to emphasize the exploitation of the public and the helpless sick when it is assumed that the graduate nurse is fitted for tasks that are as *new* to her as anything in the world can be. One great criticism of private-duty nurses is that they decline to care for certain types of cases. In many instances (not all by any means) this is due to the fact that they do not know enough about them and have not sufficient confidence in themselves to undertake them.

(*Continued on page 64*)

ATTRIBUTES WHICH MAKE FOR A SUCCESSFUL SURGICAL NURSE

By SISTER MARY FLORENCE, R.N., Ph.G., Mercy Hospital, Baltimore, Md.

THE chief requisite and outstanding characteristic of the surgical nurse is conscientiousness. Other virtues—amiability, dignity, cleanliness, resourcefulness—undoubtedly enhance her value, but without conscientiousness she must fail, and fail a debtor to human life.

No Place for a Doubt

In many, perhaps in most other instances, we may with all prudence be allowed the benefit of a doubt, but in surgical technique, we may not allow a doubt to be even considered. To be doubtful of a thing, is to be positive against its use. In surgical technique, if we doubt the sterility of material, we must consider that material unfit for use and discard it without hesitation, no matter what delay it may occasion, what material may be sacrificed, or what complications may arise as a result. Remember always that *nothing compares in value with a human life.*

We may not disregard our obligations by saying: "I did not know, I have never been taught," then leave the task for someone who does know, who has been taught. There are many things you may never know, never learn, unless you seek the knowledge. Surgical technique cannot be taught in three or four months. It is a work that requires years of close application. You can never ease your conscience by such alibis as—I am not responsible for what Dr. A does. He has been operating long enough to know how to keep clean. Miss X has been here longer than I, she should know by now how to handle catgut. These gloves are not covered, but I did not put them on. I was not assigned to this room, I just happened to be here at the time. Yes, I saw that, but I think technique can be carried to extremes.

You are responsible for everything you see, and more than this, you are responsible for everything you *should* see, otherwise you could close your eyes to all that is wrong and excuse yourself by saying, "I did not see it."

Excuses Sound the Death Knell

A nurse who gives such excuses as—I don't know, I did not see it, I was not watching, I did not notice, I *think* that is all right to use, the instruments boiled *about* twenty minutes, pronounces her own sentence, which is: "I am unreliable; I am not conscientious; I am a hazardous custodian of human life; I am a menace to this system; I am deliberately and knowingly defeating the accomplishment of the efforts of the ten, fifteen, or twenty others, who are laboring here; I am the weak link in this chain."

The surgeon, be he ever so deft and skillful, can never be successful without the conscientious preparation of all those preliminaries that fall to the lot of the surgical nurse. Patients may recover after the failure of an unskilled operator, they may recover in some cases without recourse to the knife at all; but few, if any, will ever recover if the surgical nurse fails in the duty of preparation entrusted to her. Infections follow negligence as night follows day.

The sentry who sleeps at his post, pays for his negligence with his life. What sentence should be meted out to the unworthy nurse whose negligent preparation endangers the lives entrusted to her?

Technique, not time, is the most important factor in an operating room; but time is highly important, and may save lives. Some patients who can stand a short anesthetic will surely die, if exposed to a prolonged anesthesia. Every second counts. Help the surgeon; don't hinder him.

Assurance Lacking in Beginners

Beginners are naturally timid and laudably slow until experience gives them assurance; but there are certain details which require common sense and observation more than surgical technique. Discrimination should be used and speed exercised, if a nurse would be truly helpful. To place a bucket, to turn on a light, to strip a table, to bring some non-sterile object—for instance, a pillow, a sand-bag, a stool are things which can be done quickly as a nurse can neither spill nor contaminate these objects, she should be urged to hurry.

The nurse who perpetually rushes in an excitable manner is of equal or greater menace, for technique is subjected to constant peril. Her precipitation necessitates extra vigilance on the part of the supervisor, who otherwise would be harassed by doubt as to the conscientious performance of such duties as scrubbing the specified length of time. This undisciplined mannerism—precipitation—will likewise disqualify a nurse for conscientious preparation and for the preservation of sterile materials which may have been contaminated by her heedlessness.

Be Expeditious, Not Precipitate

When "fielding," observation and self-control will avert collision and contamination, which are destructive of good order and technique. There is a happy medium; be expeditious without being precipitate.

It is doubtful if a nurse who talks while scrubbing, scrubs well. Few persons can do well one thing while talking of another. How often we hear these familiar expressions—I did that wrong because I was talking. I can never talk and work at the same time. They cannot be doing much work; they are talking too much.

When it is necessary to talk, it must be done in an undertone. This quiet not only insures more thoughtful work but adds the dignity necessarily associated with such work, and impresses observers, especially surgeons, with the seriousness of so sacred a responsibility. Frivolous, light mannerisms and conversations in the operating room are ill-calculated to convey the idea of a serious-minded nurse, bent on concentration and intent on fulfilling her mission. The work of preparation and detail must be left to us, and how can the doctors trust our work, if we appear unimpressed at such times? Does our manner in the operating room always bespeak recollection and inspire confidence? To speak of the motion picture you saw last, the time you came in last evening, the dress you are going to wear to the next dance, is most unbecoming and irrelevant.

Irrelevant Conversation to Be Avoided

Do patients in the operating room ever hear what might frighten and unnerve them? Such conversations as—Doctor A said, have ready those large knives. Have you plenty of needles? Do you think it will take longer than

two hours for this? Have the Sub-Q ready in case something happens. The last strangulated hernia died. Do you remember?—are very harmful, if heard by the patient, and should be avoided.

Dignity of manner is quite as necessary as dignity of speech. We need no special training to be dignified, we simply need to be polite to others and to respect ourselves. There are many tasks in the operating room that might be considered humiliating, but even these can be done in a self-respecting way. In the momentary absence of the orderly, the nurse may be obliged to mop the floor in the presence of the surgeons, but even mopping the floor can be done in a self-respecting way. If a footstool has to be placed for a doctor, several gentle pushes with the foot will place it, after it is once on the floor. If a message is to be delivered, await recognition before so doing. Maintain uniform self-respect in order to merit the respect of others. Familiarity, a contending and domineering air are equally undignified and reprehensible. In directing maids and orderlies, combine kind, firm determination with concise expression of requirements.

Dignity of dress is worthy of note. The use of cosmetics, perfumes and unnecessary personal effects is unbecoming in a surgical nurse. Personal cleanliness is the highest type of self-respect. Soiled linens, carelessly kept shoes, disheveled hair, missing buttons (supplied by pins), unkept nails and teeth, bespeak careless habits and lack of self-respect.

Dignity and Self-Respect

This dignity and respect for self might be misunderstood by those who have never acquired it, and lead them to something far more disagreeable, that is sensitiveness, and a kind of irritability and impatience. For instance, should a doctor who is under a great strain, show impatience at something that we think trifling and by some remark betray his feelings, we are at once offended, rehearse it all to a companion who has had a like experience and he is at once put on our list of unendurable surgeons. Maybe our feelings are hurt because he wants fine silk when we have heavy, and heavy when we have fine, he wants curved needles when we have straight ones, and vice versa. Maybe he asks us to pay attention when that is exactly what we are doing. He must see large retractors on the table, though he never uses them. His table must be arranged this way, though the other way is what everyone else wants and is what is most convenient for all.

Whether we like it or not, the surgeon is the commanding officer while he is operating, and we must make it our serious consideration to give the fullest cooperation to his wishes as well as to his needs. We must believe that his wishes voice the patient's needs and what more serious purpose have we to consider? The more competent, trained, skillful and careful attention we show him, the better will be his care of the case, the better the final result, to the human life at stake. It must be our unfailing aim to make the surgeon feel that, no matter what has been done that day or yet remains to be done, it will in no way affect him.

Personalities to Be Eliminated

Personalities must be eliminated. Never intimate by word or manner that the doctor is causing us inconvenience by going over the time that was alloted to his case. Maybe he has encountered complications, he is conscientious, he is going to take care of them. The next case can wait, this one cannot now. Avoid begrudging, unwilling service. Don't hand an extra package of sponges as though you wished to say, "I am glad the doctors are not all like him; this is eight extra packages he has used; we would have to close the operating room if he came oftener." If our supply is stinted, the responsibility is not his, but our fault. Preparedness averts the stigma of poor management, which is best evidenced by foresightedness and an equal poise of economy and accommodation.

Never let anything appear in your manner that could embarrass the surgeon or make him feel uncomfortable; avoid reproaches and resentfulness. On the other hand, be reassuring. If he asks for something that has not been provided, appear not only willing but anxious to supply it. Should he ask if he is delaying someone else, you must by some tactful answer assure him that he has no need to hurry. Imprudent persons sometimes do endless harm by making such remarks as these—I wonder will he ever finish? Doctor B would have finished long ago. Aren't you glad that is not your sister? Can't you imagine what Doctor D will say when he comes?

Remember the end-result, *human life*, and study to help the surgeon, whether, or not you like him.

Ways of Lightening the Surgeon's Burden

There are many small acts of consideration which when rendered gracefully will tend to temper the strain inseparable from operating room work. Every nurse who wishes to work intelligently and helpfully should endeavor in every possible way to make herself a reliable, competent assistant, and not a mere mechanical adjunct. Earnestly strive to develop intensive observation which alone will enable you to provide in advance what will be needed, thereby avoiding confusion and delay. Rivet your mind on the tasks at hand. Help to conserve the energy of the operator that he may be in the best possible attitude to operate.

Observation should be a characteristic of all women; without it they lack one of their essential qualities. It is best shown by kind, thoughtful acts towards others. To provide more light, to place a stool, to supply the anesthetist, to give more supplies, to anticipate the needs of the scrubbed nurse, are evidences of this quality.

Can we not imagine the feeling of calm and ease a surgeon experiences upon entering a room where he sees nurses who he knows have prepared properly for the operation and who will think and act for him as far as they may. Are we unjust judges to think that he makes a mental comparison between these nurses and some others whom he feels obliged to ask, before scrubbing, if they have this or that, for he knows that they have often failed to be helpful. Would his thoughts reveal some such comment, as: "Today of all days, to have *that* nurse, and this is a particularly trying case!"

Selfishness of Nurse Intolerable

What censure severe enough could be pronounced in condemnation of a nurse who manifests such an attitude as "Doctor A will want this or that, but I shan't bother, this is plenty good enough," as she stands by unconcerned and sees him make an awkward use of it. How unfavorably does she compare with the nurse who, with calm solicitude, asks herself over and over: "Could Dr. A wish for anything we have not provided," as she watches his every step and resolves to provide something better for the next time.

That no part of the work of the operating room may be neglected or overlooked, the duties are equally divided and assigned to the nurses. It must be the conscientious duty of every nurse to do the things allotted to her, and for which the supervisor will hold her responsible at all

times. This division will avoid the confusion occasioned by the overlapping of some parts of the work and the consequent neglect of other parts, and will thus economize time and materials. It will aid as a check on those nurses who are inclined to leave it for some one else. To avoid the danger of exposing the patient to delay, the greatest care must be observed in placing objects in perfect condition in their allotted places. If an object is not found in its usual place, we are at a loss to know where to find it, and if it be found unfit for use, what shall we do? Confusion and loss of time result.

Supervisor Invested with Supreme Authority

That the work in the operating room may be carried on with the degree of perfection required for such work, it is necessary that the supervisor be invested with supreme authority to direct her staff. From this supervisor all orders must come, if not directly, then indirectly, that is, from one of her assistants in whom she has vested a portion of her authority. For a nurse to refuse a service because the direction did not come directly from the supervisor, to fail to execute an order because the direction was general and not particular, to do only that which was expressly commanded and not that which she knew to have been intended, is to impose an additional hardship on the supervisor, whose every word, glance, and sign must be obeyed with unhesitating promptness, if all would go well.

To be perfect in all that has been said of a surgical nurse would make of a nurse a valuable assistant in the operating room; but she needs yet another asset; namely, that of guarding zealously the secrets of patients and surgeons alike. She must consider every operation she sees as a confidence given to her, of which she may not speak to anyone. Many persons are keenly sensitive of certain conditions, for instance, of malignancies, and would not disclose their condition if they knew the public were to know of it. The nurse assisting at the operation, must consider her lips sealed, for the secrets of others are in her keeping, and her standard honor must be high enough to stand the strain imposed upon her.

Nurse in Confidence Bond

To criticise a surgeon's technique, procedure, or results, is not within the province of a nurse. He should be guided in his actions by a profound knowledge, acquired through years of experience. Ignorant listeners may be influenced by the nurse, who freely gives expression to narrow, biased, and false opinions. What may seem to us the result of lack of skill is most likely the necessary accompaniment of a condition previously known to, and carefully considered by the surgeon and, when circumstances permit, often made known to the patient.

In conclusion, it may be said that although the conditions laid down in the preceding pages presuppose a very high aim with untiring efforts to reach it; nevertheless, if the surgical nurse be worthy of her calling, she must fulfill these conditions. If they appear too difficult of attainment, it were advisable for her to seek another field of work.

INFLUENCE OF THE UNIVERSITY IN MODERN NURSING EDUCATION

(*Continued from page 61*)

In what I have written, I have tried to show that many factors enter into the problem of providing adequate care for the sick in the hospitals and homes of the community. These problems are not easy to solve because they involve human relationships. The Nightingale type of training school is as inadequate to our present-day needs, as the old-fashioned horse and carriage of thirty years ago would be to our present-day transportation needs. No matter how fine the team of horses, or how strong and new the carriage, such an outfit would be incongruous because of its inadequacy. Yet the modern automobile represents an initial outlay far in excess of the purchase price of the older outfit. Just so the initial outlay for nursing education needs must be greater than that for the older type of training, but under existing conditions it will prove more adequate, and the deferred payments will not be so unfair.

Students Seek Educational Advantages

Roughly speaking, high school students may be divided into two groups; one looks for openings that bring, what to them are, large and prompt returns in money; the second looks about for more adequate preparation, and by far the largest proportion of the second group is turning to the colleges and universities. Nursing does not appeal to the first group. In the second group are found many potential students, and these students are more likely to enter a school connected with a university than any other type of school. The shortcomings and failures of schools of nursing have had much publicity in recent years. Our applicants are much more intelligent in evaluating schools of nursing than ever before and are looking for educational values that are recognized by educational authorities, hence the great value put upon a degree.

Because the whole idea of university schools of nursing is comparatively new, and the experiments in this field have been so varied, it is difficult to compare the actual cost of a university school with the cost of conducting a school without university connection, but in either case, the cost of educating the students must be met. In the case of the university school where the student is paid in terms of academic credit, the actual cost in dollars and cents will probably not be any higher than the cost of nursing care in hospitals that cannot secure students. Certainly it seems more dignified to attempt to attract students by offering recognized education rather than by paying allowances, providing uniforms, etc. Witness the schools which are trying this and note how miserably they are failing.

Even if the cost of both types is similar, is it not our duty to graduate only the best prepared nurses possible? Only in this way can we lessen the suffering and dissatisfaction that follows in the wake of poorly prepared nurses. Does it not seem reasonable to argue that the best prepared nurses will be those whose preparation is standardized and vouched for by the university? Is not this what has happened in the case of medical education?

GIVES MILLION FOR HOSPITALIZATION OF PEOPLE OF MODERATE MEANS

The Massachusetts General Hospital, Boston, has recently received a gift of one million dollars from the will of Mary R. Richardson, Newport, R. I., to be used for the construction of a branch hospital or ward for the treatment of people of moderate means. The hospital will be a memorial to Mrs. Richardson's parents.

Health results from living in the proper way. It flows from life as a by-product of actions, responses, or conditions that are wholesome.—*Williams.*

Nature is always consistent.—*Emerson.*

DIETETICS AND INSTITUTIONAL FOOD SERVICE

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THE PLACE OF EDIBLE GELATIN IN GENERAL AND SPECIAL DIETARIES*

BY THOMAS B. DOWNEY, PH.D., SENIOR INDUSTRIAL FELLOW, MELLON INSTITUTE OF INDUSTRIAL RESEARCH, UNIVERSITY OF PITTSBURGH, PITTSBURGH, PA.

A DISCUSSION of the place of gelatin in the dietary is particularly fitting at this time because recent investigations have shown that gelatin should occupy a more prominent position in general as well as special dietaries than has previously been accorded to it.[1] These conclusions take into consideration the following characteristics of gelatin: its nutritive value as a protein and efficiency as a supplementary protein, its easy digestion and absorption, its facility to aid digestion and absorption of other foods by its protective colloid and emulsifying action, its production of useful physiological effects, and its exceptional adaptability as the basis for the preparation of foods that are attractive in appearance and pleasing to the taste.

Value of Gelatin as a Protein

That gelatin is one of the easiest proteins to digest has been shown by the superposition experiments of Falta. Hawk has studied its digestibility in the human stomach by the fractional method and reports that 400 cc. of a 1.5 per cent solution left the stomach in one hour and that fruit juice preparations in gelatin left the stomach almost as rapidly. There is practically no indigestible residues in gelatin and its cleavage products are readily absorbed.

Although gelatin contains about the same amount of nitrogen as other proteins, possesses a similar calorific value and yields in the diabetic the same amount of sugar, it cannot satisfactorily serve as the sole source of protein in the diet. Like certain other pure proteins (zein and hordein are excellent examples) gelatin cannot supply all of the necessary maintenance and repair units (amino acids) required by the animal body. Tryptophane and cystine are absent and tyrosine is present in very small amounts in the cleavage products of gelatin. Gelatin has therefore been classed as an incomplete protein. It should be borne in mind, however, that this does not indicate that incomplete proteins are worthless: as a matter of fact, they are of decided value where taken in suitable combinations. Most of the natural foodstuffs are composed of mixtures of proteins, the individual members of which may be partially or totally inadequate, if fed at moderately low levels of food intake. Furthermore, these mixtures at reduced levels of protein intake show shortages of one or more essential amino acids. For example, the cereal grains are low in lysine and the legumes in cystine. As gelatin contains a relatively high proportion of the lysine radicle, but not of cystine, one would expect that the cleavage products of gelatin are well utilized where fed with many of the cereal grains, but that they are of little value in conjunction with legumes.

McCollum and his co-workers have found that gelatin is an efficient supplementary protein where fed with wheat and oats. When oat proteins were fed at 9 per cent level in an otherwise satisfactory diet, rats grew at less than half the normal expectation, but were able to grow at a normal rate to full adult size where 10 per cent of gelatin was added. The addition of so small an amount as 3.5 per cent of gelatin produced marked improvements. Similar results were obtained with wheat proteins. These observations with oats are confirmed by a very striking experiment carried out by Osborne and Mendel. They report that a rat fed on 45 per cent of oat concentrate (2.7 per cent of nitrogen in this diet) in an otherwise adequate diet, over a two-week period, gained 10 grams in weight, consuming 92 grams of the food mixture. During the succeeding 2 weeks, this animal was fed on the same diet, except that one-fourth of the oat nitrogen was replaced with gelatin nitrogen, and it gained 23 grams in weight, consuming 87 grams of the food mixture. There is a wide difference between the 9.2 grams and 3.8 grams of food consumed on the respective diets for each gram gained in body weight.

Wheat Products Improved by Gelatin

The author has found that 5 per cent of gelatin with 9 per cent of oat protein in an otherwise satisfactory diet promotes growth of rats at fully normal rate. Rats that were making very small gains in weight on oats ration (9 per cent) showed marked response in growth and general appearance when 5 per cent of gelatin was added thereto. The author has also observed that a number of products made from wheat are improved in nutritive value, as relates to protein, by the inclusion of 5 per cent of gelatin. Reference is had to white wheat and whole

*A paper presented before the Dietetic Section of the American Hospital Association, Buffalo, N. Y., October 9, 1924.

1. A critical survey of pertinent literature on the food value of gelatin is given in a report of the results of feeding tests with gelatin, entitled, "A Study of the Nutritive Value of Gelatin," presented by the author before the Division of Biological Chemistry of the American Chemical Society, Ithaca, N. Y., September 11, 1924.

wheat bread and whole wheat breakfast foods.

Experiments with barley proteins showed that they may be added to the list of cereal grains that are supplemented by gelatin. Pearled barley proteins at food intakes of 7.2 per cent supported little growth, but with the addition of 10 per cent of gelatin supported growth at almost normal rate. However, 8 per cent of pearled barley protein with 5 per cent of gelatin (the fat content of the ration was decreased) supported normal growth, while without addition of gelatin growth at half the normal expectation or less resulted. Similar improvements were noted with the proteins of whole barley. With rye proteins a decided but smaller relative improvement was observed.

It is thus apparent in certain combinations, notably those in which lysine is the limiting factor, that the cleavage products of gelatin are well utilized. When, however, these protein mixtures or pure proteins show the same amino-acid deficiencies as gelatin, its value is concordantly small. In illustration, McCollum found that maize is not improved in biological value by the addition of gelatin, presumably because zein, the principal protein of corn, yields neither cystine nor tryptophane. He reports similarly for peas with their shortage of cystine, as does Sure for the Georgia velvet bean and arachin, the globulin from the peanut.

Proteins Improved in Nutritive Value

It is interesting to note that the proteins of the Georgia velvet bean are greatly improved in nutritive value by gelatin addition when cystine is added. Similarly, Hogen has found that kafirin, an alcohol-soluble protein extracted from kafir, is partially supplemented by gelatin, as lysine is the first limiting amino-acid and cystine the second. According to Sure, edestin at 6 per cent intake is inadequate but supports fair growth upon the addition of 6 per cent of gelatin. A further improvement is obtained with the addition of 0.4 per cent of cystine. From this result and subsequent experiments additions of the amino-acids, lysine, proline and cystine, to edestin, Sure has concluded that proline is an essential amino-acid for growth. Gelatin is rich in proline as well as hydroxyproline.

It is apparent that many of the proteins extensively used in the dietary are improved in nutritive value when relatively small proportions of gelatin are also included. That these improvements result from small additions is of practical significance because in the general dietary gelatin is customarily consumed in small amounts (dry basis) as jellied consomme, desserts, salads and meats in gelatin jelly. Its physical properties preclude the use of larger quantities without decrease in the pleasing appearance and palatability of the resultant preparations.

A Protective Colloid and Emulsifying Agent

Another characteristic property of gelatin that is decidedly pronounced even in exceedingly small concentrations is its action as a protective colloid and emulsifying agent. It is maintained by colloid chemists that colloids of the emulsoid type exert a significant influence upon the digestibility and absorption of other foods. These effects are most pronounced when gelatin is fed with milk and products prepared from it. For example, in the feeding of bottle babies with cow's milk, it is common practice to make the milk food more acceptable by the addition of such protective agents as gelatin, barley water concoctions and sodium citrate.

It seems that cow's milk with its high proportion of casein to lactalbumin (a natural protective agent) is much less stable towards acid and rennin than is human milk. Consequently cow's milk curdles readily in the stomach and may form such tough masses, composed of casein and the fat carried down by it, that the enzymes of the gastric juice are unable to perform their proper function. Furthermore, the gastric digestion having been ineffective, the intestinal digestion is seriously impaired. With the addition of a protective agent such as gelatin, curdling in the stomach may be inhibited or modified in character to loose finely divided masses that are easily penetrated by the digestive enzymes. Likewise gelatin is an excellent emulsifying agent, aiding in the maintenance of fats in emulisfied condition, an action that presumably continues in the intestines, because gelatin is active in either an acid or alkaline medium.

Over forty years ago Jacobi made the very pertinent statement that gelatin or gum arabic in cow's milk modified the coagulum in the stomach and facilitated the digestion and absorption of nutrients, as through their use less stercus was formed.

That the addition of one per cent of gelatin to ordinary pasteurized milk improves its nutritive value to a marked extent has been shown by a series of feeding experiments with the white rat carried out by the author. In these tests gelatin was dissolved in grade A pasteurized milk by first soaking in the cold and then warming to pasteurization temperature or less. This mixture and the plain milk were fed to split litters of young rats (taken shortly after weaning) for a period of twenty-seven weeks. During six weeks of the early growth period an accurate record of food consumption was kept. The food intakes per gram gains in body weight were 21.6 grams of milk and 16.9 grams of gelatin-milk, corresponding to 2.81 grams of milk solids and 2.27 grams of milk solids plus gelatin for the respective rations.

Increased Utility of Milk Nutrients

If this result is expressed as percentage of whole milk successfully replaced by gelatin, the saving is 27.7 per cent, or, considering gelatin as part of the total solids in the diet, the saving of solids is 23.7 per cent. In these tests, as with other dairy products fed in liquid form, it was observed that the feces were better formed where gelatin was present in the diet; furthermore, tendencies to diarrhea were inhibited. The growth of the animals on gelatin-milk was more rapid and they attained larger adult sizes. The males on milk showed a tendency to decline towards the close of the tests, while the male rats on gelatin-milk continued in excellent health. The females on gelatin-milk reflected better nutritional status by increased productivity, although they were not able to rear their young to full weaning period.

These observations on the increased utility of the nutrients of milk in the presence of 1 per cent of gelatin were confirmed by the results of a second test with rats of a hardier strain, carried through a period of six weeks. In this test, five rats gained a total of 345 grams in body weight on a diet of whole milk, while five rats, brothers and sisters of the last mentioned animals, gained 418 grams on gelatin-milk diet. The increased utilization of food for growth was not so great as previously observed but was still decided, being 24.4 per cent and 16.6 per cent, as calculated above.

Another interesting illustration of the improvement of a dairy product in nutritive value by the inclusion of a small proportion of gelatin is found in ice cream. This example is of dietetic as well as industrial importance as no less than ninety per cent of commercial ice cream contains about one-half of one per cent of gelatin, that

is, one part of gelatin to each two hundred parts of ice cream mix. The purpose of adding gelatin is to prevent the ice cream from becoming coarse and grainy while it is being delivered to the consumer. It should be borne in mind that the ice cream mix, when frozen, contains much of the watery portion in the form of minute crystals. These particles are so small that the ice cream is smooth and velvety in appearance and taste. However, unless a protective agent (gelatin has been found by experience to be the most efficient) is present, the small crystals grow to larger size and the ice cream in the course of 24 to 48 hours becomes coarse and unpalatable. When gelatin is present in ice cream, it is believed to form a thin protective coating or capsule about these crystals, which inhibits their growth. Gelatin is also a good emulsifying agent and aids in keeping the butter fat in a more stable form. It will be observed that the properties that cause gelatin to improve the texture, palatability and keeping qualities of ice cream are the ones that aid in the digestibility and absorption of the ice cream by the animal body. In addition, the amino-acids contained in gelatin doubtless serve directly to increase the protein value of the product.

The author has investigated the influence of gelatin upon the nutritive value of ice cream by means of feeding experiments with animals. In these tests four groups of white rats were fed from weaning time for twenty-two weeks thereafter on plain ice cream (a fair representation of milk solids, fat and sugar of commercial ice cream) and this same plain ice cream plus 0.5, 0.75, and 1.0 per cent of gelatin, respectively. For brevity, the results obtained with the plain ice cream and this ice cream plus 1 per cent of gelatin will only be discussed, as the observations with the other two diets were roughly intermediate. During the first eight weeks of the experiment, the five rats fed on plain ice cream gained a total of 454 grams in body weight, while their brothers and sisters (5 animals) fed on this plain ice cream containing 1 per cent of gelatin gained 581 grams. Furthermore, while the first group ate an average of 13.3 grams of the food for each gain of one gram in body weight, the latter group (gelatin-ice cream) consumed only 11.2 grams of the diet,—that is, the 1 per cent of gelatin increased the utilization of ice cream for growth to the extent of almost 20 per cent. At the end of the test animals on the gelatin ice cream were much larger in size (about 40 grams in weight) and healthier in appearance. An examination of their femurs showed that the bone development was greater for those animals whose diet contained gelatin.

These results are of significance to the dietitian because they show that the customary practice of including gelatin in the ice cream for palatability provides the public with a more nutritious product, one that is easier of digestion and more complete of assimilation. They also indicate that the protective colloid and emulsifying action of gelatin must be an important consideration in planning many special dietaries.

Gelatin in General Dietaries

Hawk has studied by the fractional method the digestion of milk and gelatinated milk (1 per cent of gelatin) in the stomach of man. He found that finer and softer curds were formed in the presence of gelatin and that the digestion period was shortened. It would seem that the smaller, softer curds of gelatinated milk absorb more readily the acid juices of the stomach and hence become more rapidly digested.

The results of scientific research therefore show that, in the general dietary, a true conception of the place of gelatin can only be formed by taking cognizance of its protein value where fed with other proteins and of its colloidal properties, particularly in dairy products and high fat diets. Moore and Krombholz advocate the systematic inclusion of protective and emulsifying agents, such as gelatin and albumin, in the dietaries of normal adults, in order that fats may be maintained in finely divided emulsified condition and thereby be more amenable to the action of the digestive enzymes.

Gelatin in Special Dietaries

In regimens the preceding facts as well as other considerations regarding gelatin assume greater relative importance than in the dietaries of normal adults.

Theoretical deductions, experimental evidence and clinical experience[1] demonstrate that gelatin by virtue of its colloidal properties is an aid in the digestion and assimilation of the nutrients of cow's milk by infants and young children. The advantages of gelatinated milk in infant feeding are as follows:—protein content is increased, food value is increased, volume is not appreciably increased, and digestibility is increased. It is therefore especially suitable for malnourished infants, whose digestive capacity is always diminished, and it facilitates giving sufficient food to meet nutritional requirements in such cases.

Hawk has recently reported on tests with such cases. Eight children from three to eight months of age, suffering from digestive disorders or malnutrition, some with large curds in vomits and stools, were placed on gelatinated milk for from six weeks to four months. Decided improvements in nutrition were noted in all cases and no untoward effects were observed.

In co-operative work with a Pittsburgh hospital, the author has observed a number of recoveries of very young infants, where 1 per cent of gelatin was added to the ordinary milk formulas upon which they were failing.

For normally growing children, gelatin desserts have long met with medical endorsement. With undernourished children the advantages of more extensive use is indicated. In cooperative work with food specialists in a Pittsburgh school, the author noted that underweight children from six to thirteen years old gained in weight to a greater extent when gelatinated milk was given to them in addition to their regular dietary than when plain milk was added to their dietary.

For fever, tuberculosis and diabetic patients, the use of gelatin, as a carrier of more concentrated foods and as an aid to the better utilization of these foods by the body, has met with the approval of successful practitioners. From his experiments with the phloridzinized dog, Lusk has concluded that the great waste of body proteins that takes place in diabetes belongs to Rubner's category of dynamic protein metabolism, for which gelatin may be largely used as a substitute. It seems that in the diabetic, the waste of body protein is spared to the extent of 63.7 per cent by the administration of gelatin, whereas only 30 per cent is saved in ordinary fasting. It should be borne in mind that gelatin does not furnish a complete amino-acid mixture for the repair of body protein and in consequence cannot be used successfully as the sole source of protein for any considerable period. Doubtless, in

(*Continued on page 88*)

1. See, for example, Jacobi "Intestinal Diseases of Infancy and Childhood," *1887*, 79; Starr and Wescott "Diseases of Children," *1900*, 23; Griffith, "The Care of the Baby," *1908*, 386; and Friedenwall and Ruhrah, "Diet in Health and Disease," *1913*, 295 and 46. On the Utility of Gelatin in Chronic Intestinal Infection, see Herter, "Infantilis from Chronic Intestinal Infection," *1903*, 191.

HOSPITAL EQUIPMENT AND OPERATION

With Special Reference to Laundry, Kitchen and Housekeeping Problems

Conducted by HERMAN SMITH, M.D., Superintendent
Michael Reese Hospital, Chicago, Ill.

BATTERY INSTALLATIONS FOR EMERGENCY SERVICE

A COMPLETE and modern battery installation for emergency service is installed at the Wesley Memorial Hospital, Atlanta, Ga. The battery consists of fifty-eight cells type E-23 oxide, installed in glass jars on single tier wooden racks. The battery has a capacity of 114 amperes for a period of three hours.

Under normal conditions the lighting of the hospital is provided by current from the local lighting company, which is furnished in the form of alternating current for distribution on a 110 volt-220 volt three-wire system throughout the building. The most important lighting circuits are grouped together and arranged to be connected to the battery as a two-wire 110 volt circuit in case of failure of the alternating current supply. The capacity of the battery would carry this load for a period of over three hours. The chances of all of these rooms being in use at the time of an interruption of the normal power supply is quite remote, so that there is provided a very liberal reserve capacity to take care of any ordinary interruption of the normal supply.

In case of an emergency, the operation of this battery is entirely automatic and is controlled by a main relay or contactor which is held in a closed position by a coil connected across the alternating current circuit. Should the power fail, this relay opens, tripping the three-pole switch which connects these special lighting circuits to the A.C. circuit, and the opening of these switches automatically closes the three switches which connect these

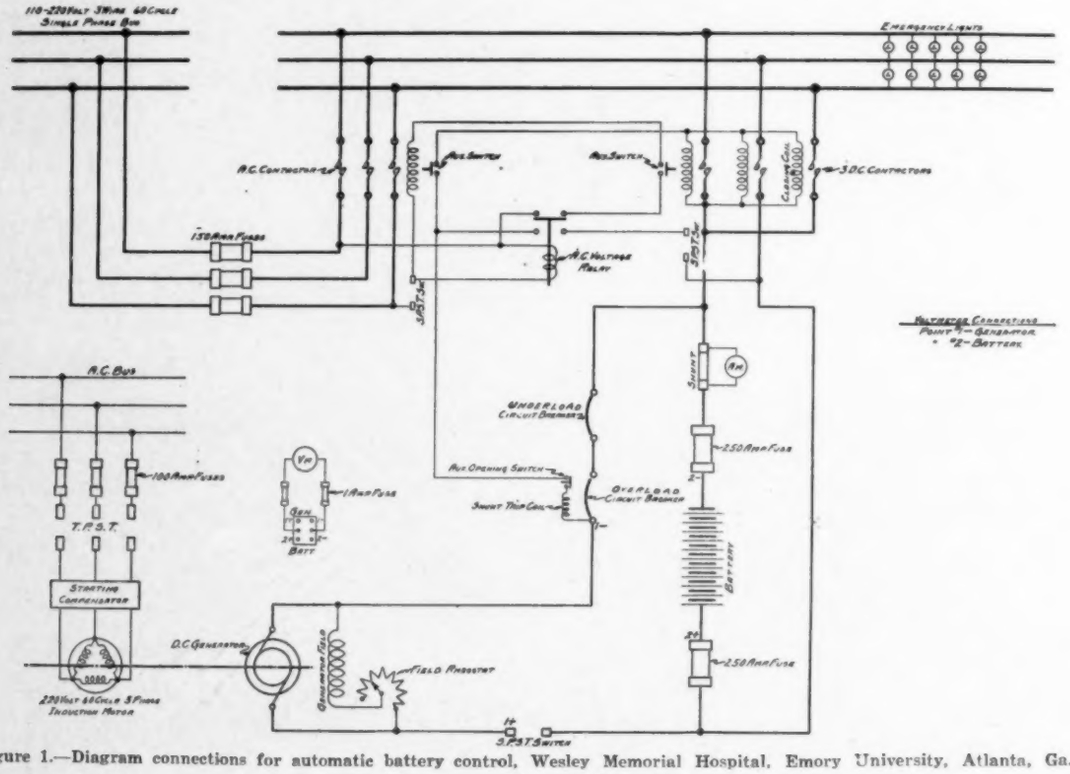


Figure 1.—Diagram connections for automatic battery control, Wesley Memorial Hospital, Emory University, Atlanta, Ga.

emergency circuits thus provided for serve three operating rooms, each requiring 800 watts, and three delivery tables each requiring 1,600 watts. In addition to this there is a circuit for supplying the halls requiring about 1,300 watts. The total load, in case all of these circuits are in use, would amount to 110 amperes or thereabouts, so that the circuits to the battery. When the power is restored the special lighting circuits are automatically disconnected from the battery and reconnected to the A.C. circuit. (See diagram.)

The current for operating the signal system of the hospital is also taken from the battery in case of an emer-

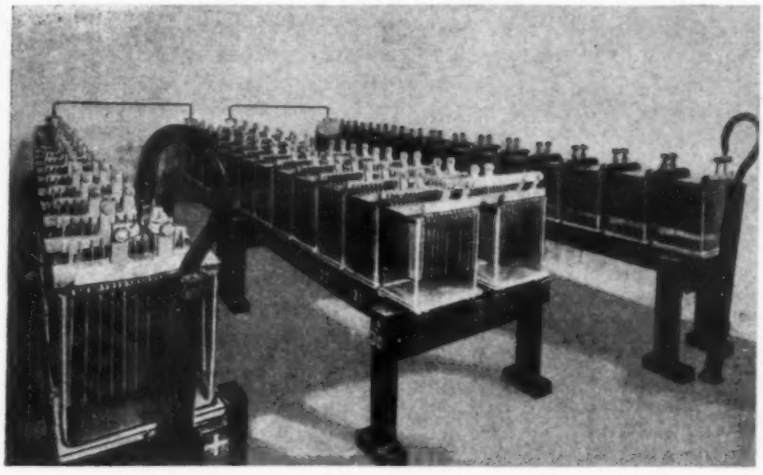


Figure 2.—Exide batteries to furnish emergency current, Wesley Memorial Hospital, Atlanta, Ga.

gency interruption of the power supply.

The battery installation at the City Memorial Hospital, Winston-Salem, N. C., consists of fifty-six cells Type E-7 chloride accumulator installed on shelves in five tiers. The rated capacity is thirty amperes for three hours or sixty amperes for one hour. This battery is held in reserve for lighting the operating room in case of failure of the normal power supply, but the switches are not automatic but are operated by hand. There is a double throw switch in the operating room enabling the attendant, in case of an interruption of the A.C. current, to throw the lighting circuit over on to the battery. (See figure 5.)

Colorado State Hospital Emergency Battery

The battery installation at the Colorado State Hospital, Denver, consists of two batteries each consisting of fourteen cells type E-7 chloride accumulator, each battery having a capacity of thirty amperes for three hours. A Tungar rectifier has been installed for charging these batteries. A special low voltage emergency lighting circuit provided with twenty-eight volt lamps is run from these two batteries to each of the four operating rooms. Each operating room is equipped with a special spot light fixture

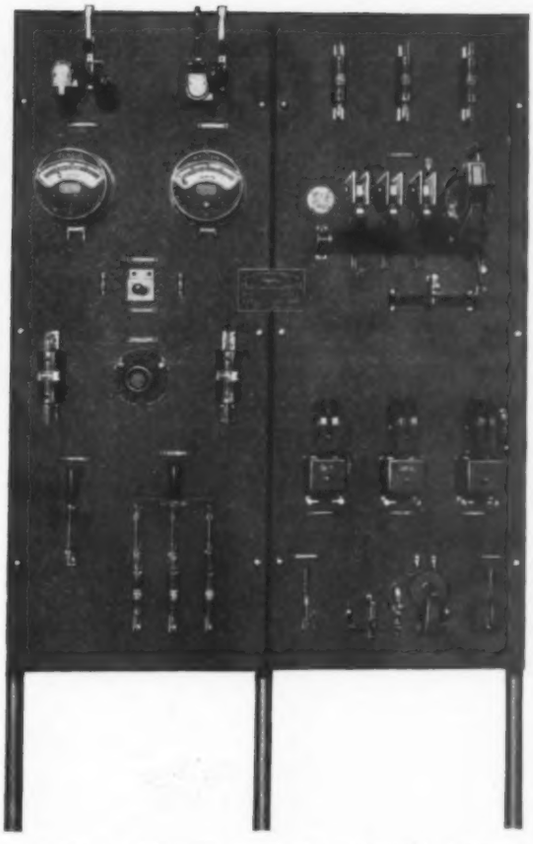


Figure 4.—Automatic switchboard at Wesley Memorial Hospital, Atlanta, Ga.

provided with a flexible cord which, in case of failure of the normal lighting supply, may be plugged into a wall socket connected to the batteries.

The Hospital of the Minnesota Steel Company, Duluth, Minn., has a battery installation consisting of fifty-six cells Type EERG-9 oxide, having a capacity of forty am-

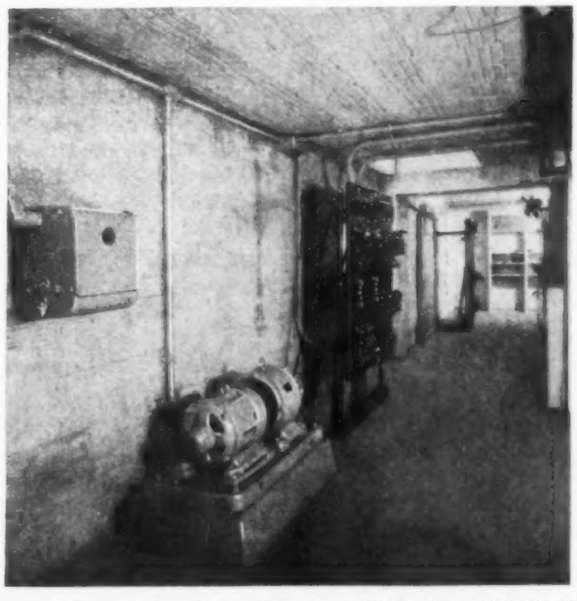


Figure 3.—Battery charging equipment at Wesley Memorial Hospital, Atlanta, Ga.

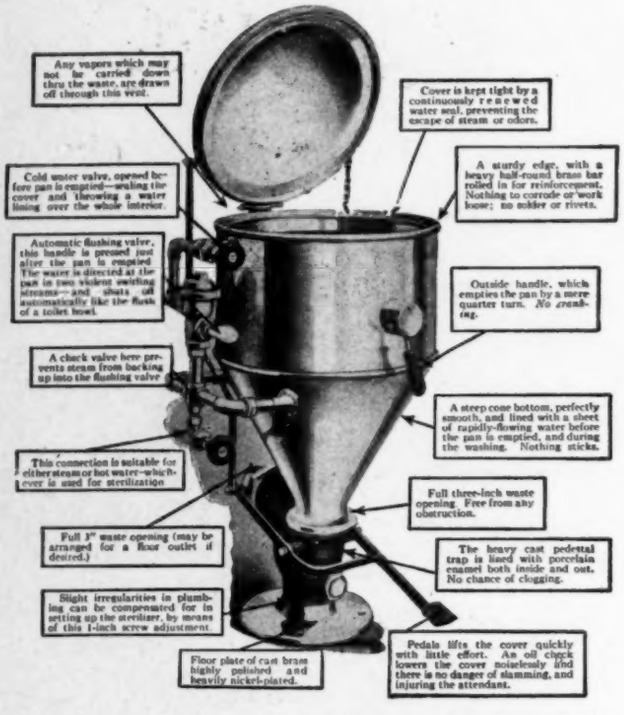
Figure 5.—Battery and charging equipment, City Memorial Hospital, Winston-Salem, N. C.

peres for three hours. A special lighting circuit is arranged and provided with a double pole switch, which, in case of emergency, may be thrown by hand to disconnect the circuit from the A.C. line and connect it to the battery. The battery is charged by means of a mercury arc rectifier from the A.C. circuit and is given a fresh charge about once a month.

BEDPAN STERILIZER

No hospital executive has ever questioned the real desirability of a bedpan washer and sterilizer, provided that in everyday usage it would perform as it is intended.

Thorough cleaning and sterilizing of pans is the real end in view, but an equally important consideration is the continued interior cleanliness of the fixture itself—otherwise, the apparatus is not worth floor space. For years this has been a drawback to the universal acceptance of washers.

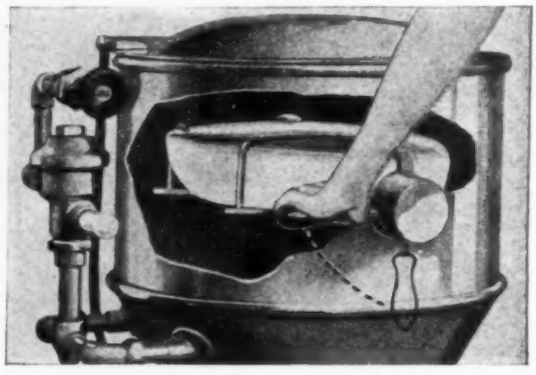

Any vapors which may not be carried down thru the waste, are drawn off through this vent.
Cover is kept tight by a continuously renewed water seal, preventing the escape of steam or odors.
Cold water valve, opened before pan is emptied—sealing the cover and throwing a water lining over the whole interior.
A sturdy edge, with a heavy half-round brass bar rolled in for reinforcement. Nothing to corrode or work loose; no solder or rivets.
Automatic flushing valve; this handle is pressed just after the pan is emptied. The water is directed at the pan in two violent swirling streams—and shuts off automatically like the flush of a toilet bowl.
Outside handle, which empties the pan by a mere quarter turn. No cranking.
A check valve here prevents steam from backing up into the flushing valve
A steep cone bottom, perfectly smooth, and lined with a sheet of rapidly-flowing water before the pan is emptied, and during the washing. Nothing sticks.
This connection is suitable for either steam or hot water—whichever is used for sterilization
Full three-inch waste opening. Free from any obstruction.
Full 3" waste opening (may be arranged for a floor outlet if desired.)
The heavy cast pedestal trap is lined with porcelain enamel both inside and out. No chance of clogging.
Slight irregularities in plumbing can be compensated for in setting up the sterilizer, by means of this 1-inch screw adjustment.
Floor plate of cast brass highly polished and heavily nickel-plated.
Pedals lifts the cover quickly with little effort. An oil check lowers the cover noiselessly and there is no danger of slamming, and injuring the attendant.

Now a manufacturer claims to have developed a fixture that, from its design, cannot but keep itself clean. The washer can properly be said to have no bottom, but only very steep side walls in the shape of a cone, terminating in a regular toilet waste outlet (see illustration). These side walls, while the pan is being emptied and washed, are continually flooded by a violent sheet of water (as in a toilet bowl) which sweeps everything down through the waste outlet. The natural result is an interior on which nothing collects or sticks.

A standard automatic flushing valve throws two powerful, cutting streams of water against the inside of the pan. After this violent washing, the valve automatically closes.

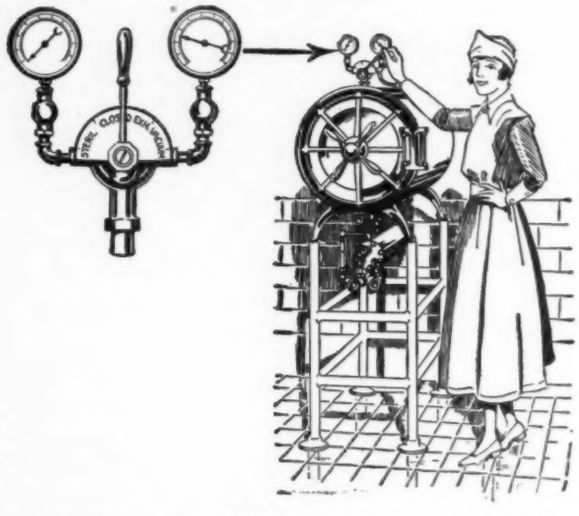
Another feature intended to lighten the nurse's task has been to eliminate all unnecessary handling of the bedpan. It is only necessary to place it in a rack which automatically adjusts itself to various sizes of standard pans. There are no spring clips to bother with, and the pan can't get away. The nurse never has to "fish" for a dislodged pan in the bottom of a hot sterilizer. No cranking is necessary, either. Steam vapors and odors cannot escape around the deep water seal. Those vapors not drawn through the waste by the violent down suction of the water, are carried off through a generous size vent in the rear. The seal is so perfect on the cover that no screw clamps or other fastenings are necessary.

Furthermore, the cover lift is fitted with an oil check, so that careless closing cannot injure the operator; besides, it lets the cover down noiselessly.



AN IMPROVED STERILIZER CONTROL VALVE

A new valve for dressing sterilizers has recently been perfected by one of the large hospital supply houses. The valve, which has a four-way control, is an ingenious mechanical device. It has a solid bronze casting with but a single operating part, that of the revolving plug. All



rubber, leather and other packing have been eliminated.

The casting itself is fitted with interior channels interconnecting with the revolving plug which also has bores leading to the pressure gauge, pressure and vacuum gauge, the sterilizing chamber and the steam jacket.

The revolving plug is manipulated by means of a small lever handle with a pointer setting against a dial which indicates what condition exists within the sterilizer, such as close, sterile, exhaust and vacuum. The gauges registering the pressures and the vacuums, as well as the rapid vacuum device form an integral part of the four-way valve.

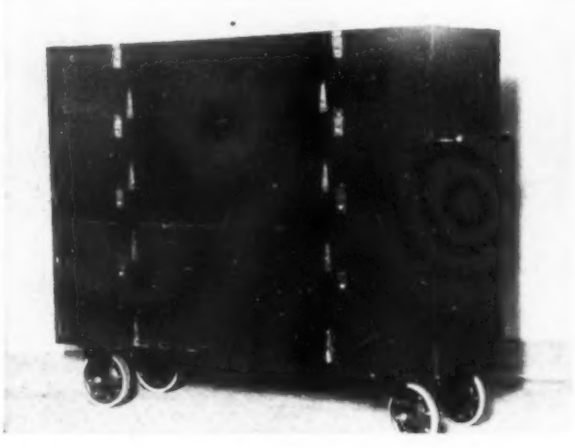
The whole valve is mounted in a compact assembly with the vacuum device and the gauges in front and directly above the door of the sterilizer, instead of at the rear.

FOOD SERVICE CART WITH TRAY RACK

By JACOB GOODFRIEND, Montefiore Hospital for Chronic Diseases, New York, N. Y.

MANUFACTURERS of food trucks have been studying and experimenting with various types of food conveyances for quite some time, but have been unable to produce a satisfactory truck for tray service. Those with electric heating units have met with a measure of success, but special provision had to be made for the transportation of cold foods, such as butter, jello, custards, etc. It was also found that the napkins and tray cloths discolored from the heat.

Thus trucks were constructed with separate hot and cold sections and many types of these are in existence today. However, they are usually of a heavy type, an undesirable factor in a food cart, especially in hospitals built on the pavilion plan, where the kitchen is at a considerable distance from the ward. Another disadvantage is that the cold dishes must be added to the tray in the ward, causing delay.



It is therefore generally conceded that a plain closed cart is the ideal means for the transportation of "set up" trays, but the right type of doors have presented a problem.

Special Type of Door Needed

A great deal of time and money has been spent experimenting with various types of doors. It was found that ordinary doors, opening horizontally, as do doors on a safe, occupy too much room in the kitchen, especially when a large number of carts are required. With the doors open, each cart needs space equal to twice its width.

A very well-known truck manufacturing concern then constructed the doors so that they opened vertically, in two sections, the upper half folding over the top of the cart, and the lower to the ground. This type of door was found impracticable, as the least dent in the doors prevents them from closing snugly.

The type of truck pictured above was designed and made at the Montefiore Hospital and is being used successfully. It consists of four shelves with an individual door to each shelf. These shelves when opened fall at an angle of 90° forming a tray rack, for which purpose it is used while setting up the trays. It is constructed entirely of wood and weighs approximately 200 pounds when empty. We are now making one of wood with a metal frame which will be more substantial. The top three shelves are ten inches apart and the bottom one twelve inches. More space is provided in the bottom shelf to allow for coffee and soup pots, etc. Two swivel wheels are placed on the controlling end, where the handle is located, the other two being stationary. Large hot water plates which have been successfully used in the Mount Sinai Hospital for some time (designed by Miss Lulu Graves, dietitian) are used for the meat and vegetables. To avoid spilling in transit, soup and coffee are sent up in large covered containers placed on the bottom shelf. These are added to the trays when the truck reaches the ward.

Hot Water Plates Successfully Used

Casseroles have been used very effectively in the Presbyterian Hospital and other hospitals in place of the hot water plate for the meat and vegetables, but the hot water plate is found to give better satisfaction and presents a tray more pleasing to the eye.

The following are a few of the desirable features of this cart:

(1) Individual door for each shelf permitting trays in the other compartments to retain their heat while one door is open.

(2) Less space is required, as no allowance need be made for opening doors; conservation of space in a kitchen is a very important factor.

(3) Elimination of the use of a tray rack, as truck serves as a tray rack when doors are open.

(4) The hot and cold dishes can be placed on the tray in the kitchen and a little cracked ice added to the butter, etc., if desired.

(5) Tray cloths and napkins are not discolored from the heat, as is the case in the electric truck.

(6) Strips of wood on the shelves between trays keep the trays snug and in their place while the cart is in transit.

(7) The cart being very light in weight, is easily handled and controlled.

(8) All corners on the inside are rounded so that cleaning may be accomplished easily and the cart may be kept dust-free and sanitary at all times.

THE SCIENCE OF SPOTTING APPLIED TO DAILY USE*

By EDNA I. AVERY, Head of Textiles and Clothing, State College of Washington, Pullman, Wash.

SPOTTING is the trade term for the cleaning of clothes not by complete emersion in water, that is, laundering, nor in some other solvent (which is dry cleaning) but by the removal of spots, commonly called stains, from certain parts of clothing. The insurance of clean clothing means more than the Monday washday. It means spotless clothing every day and at all times. Keeping clothes immaculate is most difficult, for no matter how careful a person may be the clothing easily takes up bits of soil and dirt as one goes about the duties of daily life. Unless these spots are removed and not allowed to accumulate one finds that the reward of cleanliness has been forfeited and one becomes untidy, careless and slovenly—all of which are ungodly characteristics. It will not be necessary to send many clothes to the professional cleaner to have these disfiguring spots removed. Any one in the home may be a "spotter" with a little knowledge and practice and need only resort to outside sources in exceptional cases. Care in following these directions ought to bring successful results.

General Directions for Spotting

(1) *Know what caused the stain.* If possible find out what caused the stain, for each stain remover serves a specific purpose and it will save experimenting and doubtful success if one knows that the spot came from fruit, blood, or something else.

(2) *Know the kind of material to be cleaned.* This means that one should be able to tell whether the garment is made from cotton, wool, silk or artificial silk, etc. The reason for this is that some chemicals will remove the stain but will also injure certain kinds of material and hence ought not to be used. Unfortunate results happen if one does not consider the goods to be cleaned. White and colored goods, cotton, linen, silk and wool should not always be treated in the same way. It is well at this time to note the weave and texture of the material as to whether it will stand any rubbing without injuring the appearance of the cloth.

(3) *Beware of handling colored materials.* If a garment is undyed the work of removing stains is comparatively easy but if the stain is upon a dyed material one must first make sure that the color will not be taken out when the stain is removed. No two dyes act alike and the only safe way is to test the spotting chemical on a piece of the garment to see that the color is not attacked.

Method of Procedure

(1) *Remove the stain at once.* That is, remove the stain when it is fresh and before it has had time to enter the cloth and make a fixed compound. This would be a resistant spot difficult to remove.

(2) *Work in the light.* Better success attends one for the spot can then be easily seen and the material will not be worked longer than it is necessary to remove the spot. Light, that is sunlight, is a good stain remover.

(3) *Work upon a clean pad.* Place the material spot down upon a clean pad of cloth. A turkish towel is most excellent but blotting paper or absorbent paper will do. As the spotting liquid is applied, the stain will be absorbed by this pad. There is less tendency for the stain and solvent to spread.

(4) *Spot with a tampion.* This is a piece of cloth rolled into a ball with which the solvent is applied. When spotting colored materials make a tampion of the same material in case the color of the garment has a tendency to run, if it runs from the garment it will also run from the tampion and thus cover up any loss of color on the garment.

(5) *Daub with the tampion.* Dip the tampion in the stain remover and pat it on the spot. Do not rub, as this might disturb the weave of the material and that would show as badly as the spot. Never rub stains but rely upon the solvent to remove the spot.

(6) *Use soft water.* If this is not possible at least boil the water and this will remove some of the hardness It can then cool if it is not desirable to use warm water on the spot.

(7) *Try simplest method first.* When in doubt as to what to do begin with the simplest and least harmful remedy first.

Work carefully. Experiment on a sample. Rub gently. Haste makes waste in taking out spots.

Theory of Removing Spots

The theory of removing stains is both a chemical and a physical one. They may be dissolved from the garment, bleached out or absorbed. It is upon one of these three actions that one depends for success and not upon friction-rubbing, which might injure the material by getting the threads out of place or actually making holes in the cloth. Try to select the right method for the right stain and let the *chemicals* do the work.

The removers that one may keep on hand in the home may be classed as follows:

Solvents: Water—hot or cold, oxalic acid, hydrochloric acid, ether, chloroform, gasoline, carbona (or carbon tetrachloride), benzole, alcohol, glycerine.

Absorbents: blotting paper, unglazed paper, unglazed cloth, fullers earth, chalk powdered magnesium, corn meal, flour, starch, talcum powder.

Bleachers: sunlight, hydrogen peroxide, sulphur borax, ammonia, potassium permanganate, sodium perborate, oxalic acid (poison), citric acid, Javelle water.

When rules fail look at this list and decide if an absorbent, solvent or bleacher would do and select from this group.

Special Action of Some Chemicals

Acetic acid is very good to brighten colors. It is safe to use but in concentrated form may be annoying to the hands.

Glycerin is a solvent for alkalies, coffee, chocolate and dyestuffs but it is inflammable. It softens many resistant spots.

Borax is a bleacher and may be used hot or cold. It is harmless.

Citric acid, if taken internally, is poisonous. Tartaric acid may be substituted for it.

Oxalic acid may be used in hot or cold solutions. This is very poisonous. It is wearing on all vegetable fibers such as cotton and linen.

Potassium permanganate is not hard on materials. It is a bleacher of color and stains. It requires the after use of another chemical like oxalic acid to remove the stain it makes and this second chemical may be and

*This is the first of two articles on the subject of spotting prepared for THE MODERN HOSPITAL by Miss Avery.

often is hard on materials

Benzole is a solvent for iodin, sulphur, resin, rubber, phosphorus as well as fats. It will also remove the ring left after using turpentine.

Tartaric or acetic acid will brighten and give a rustle known as "scroop" to silk materials.

Ether and chloroform are dangerous to use except where there is a current of air as out of doors or before an open window. In a closed room one might become unconscious by inhaling the fumes.

Gasoline must never be used in a room where there is a fire, light or electric motors or switches that may be turned on. One tiny spark might cause a fire. The fumes of gasoline are heavy and sink to the floor, hence they might travel to another room where there was a flame and cause fire. The only safe place for using gasoline is out of doors and preferably on a sunny day.

Benzole acts as gasoline does so that care must be taken when using it. There is practically no danger, however, if one observes these cautions.

Javelle water is a wonderful remover of color but is hard on all materials and should be well washed out. It ought to be used on cotton and linen only as it will destroy silk and wool.

A chloroform ring upon silk may be avoided by wetting out the surface to be spotted with water first, then apply the chloroform inside the water ring and remove the spot. Another way is to use the chloroform first and erase the ring with gasoline.

Water, cold or hot, is not dangerous to materials, provided that they are not rubbed too hard. It may, however, be a source of removing color.

Carbon tetrachloride (carbona) is a solvent for fats that is not explosive so that it can be used with safety. It does not affect dyes, nor does it leave rings.

Neutral soap may be used with the volatile liquids like alcohol, carbon tetrachloride, chloroform, etc. Sometimes soap is a great help in removing stains when these liquids are used.

Formulas for Solutions

Some of the solutions needed may be cheaply prepared at home while others can be easily secured from drug stores at slight expense. Every housewife should keep cleaning solutions on hand the same as other household remedies. They should be safely corked in bottles and on a shelf out of reach of children. There is no danger attached to using those listed here, if the precautions given are adhered to. Never put any solutions in the mouth and touch them as little as possible with the hands. If the tampion is used it saves the hands. Do no rubbing to speak of but rather leave the chemical to do the work.

Javelle water.—One-half pound chloride of lime dissolved in two quarts cold water. One pound washing soda dissolved in one quart boiling water. Pour the clear liquid from the chloride of lime into the soda solution. Let the mixture settle and then strain the liquid through a cloth into bottles. Cork and keep in a dark place.

Potassium permanganate.—Dissolve one teaspoonful of crystals in one pint of water.

Oxalic acid.—Dissolve one ounce crystals in three-fourths cup hot water. Mark "Poison."

Hydrogen peroxide.—Add a few drops of ammonia to the hydrogen peroxide just before using. This makes it work more quickly.

The above solutions are all bleaching agents, as referred to in the removal of various types of stains.

Hydrochloric acid.—Purchase at a drug store and get a ten per cent strength. This is a strong acid and should not be dropped upon the skin.

Ether.—Use commercial strength and keep in a cool place.

Chloroform.—Use commercial strength.

Gasoline or Benzole.—Keep only small quantities, about a pint, in the house and put that far away from any heat or flame. Keep tightly corked.

Alcohol should be ninety-eight per cent strong. Keep away from a flame. It is put up commercially and so altered that it is unsuitable for drinking. In fact it is a rank poison and should be so marked. It can be mixed with ether and chloroform and so mixed makes a good grease remover. Sometimes a benzene soap can be added to alcohol to help clean the material.

Glycerine.—Purchase at drug store. Strength is fifty per cent.

Fuller's earth, chalk, talcum, magnesium, etc., can be bought at drug stores.

Carbon tetrachloride is sold in drug stores under the name of Carbona.

Acetic acid.—Use ten per cent strength and if it affects the color dilute it by adding an equal amount of water. If tartaric, citric and oxalic acid are purchased in liquid form get ten per cent strength.

Hydrogen peroxide.—Buy at a drug store and when using it add a small amount of ammonia to free the oxygen.

Sulphur can be bought in powdered form. A small amount is all that is needed.

Borax.—Buy in crystal form and use in hot or cold solutions.

Sodium perborate.—Comes in powdered form. Take one and one-half ounces to a pint of distilled water. Bottle. For very bad stains have your druggist put up the following: A concentrated solution of sodium perborate, one and one-half ounces acetic acid and a few drops of phosphoric acid. Apply this solution with a spotting stick or tampion. Keep from getting it on the hands.

Glacial acetic acid.—This is the concentrated strength.

Burmol.—This is a commercial preparation that is very helpful in removing many stains but as it is used almost exclusively by the launderers and dry cleaners it may be difficult to procure.

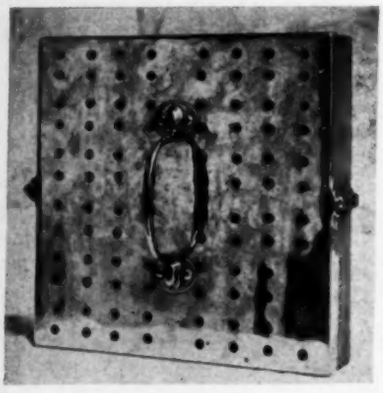
BASIN FOR STERILIZING TUBE CATGUT

By SAUL S. SAMUELS, M.D., and JOSEPH TURNER, M.D., Mount Sinai Hospital, New York, N. Y.

The container, to be described, has been in use in the operating rooms of the Mount Sinai Hospital, New York, N. Y., for the past two years and has proved its usefulness in the routine handling of tube catgut. There are, at the present time, six sizes in both plain and chromic boilable tube catgut in general use at the hospital. The task of keeping these various sizes separated and so arranged as to be easily and promptly available during an operation was quite difficult and time consuming under a former plan of tying up a bundle containing a dozen or more tubes of assorted sizes and spreading them upon a towel or in an ordinary flat basin. Furthermore, this method necessitated the reboiling and reassortment of the tubes between operations. Another objection was the danger of breakage of the catgut tubes by the heavier metal instruments in the sterilizer.

To obviate these drawbacks in the operating room routine, the writers designed a special catgut basin. This is made of No. 22 gauge nickel plated copper, measures

9x9½x1½ inches and is divided by metal partitions into thirteen compartments. The eleven larger compartments are 1½x4¾ inches; the two smaller compartments are 1½ inches wide by 2⅝ inches long. Each large compartment can hold ten tubes of catgut while the small compartments are used for needles or small spools of silk. The cover, made of the same material as the basin, is perforated with numerous ¼-inch holes so as to allow, after sterilization, the draining of the water by inverting the basin. The lifting handle is strongly made of the same metal. At each end, the cover can be fastened to the basin by two metal trunk clasps.

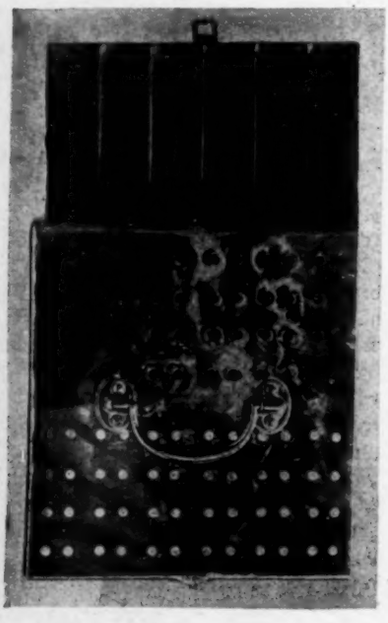


When setting up the operating room, this basin is filled with the catgut, plain on one side and chromic on the other, the various sizes being arranged serially. Each compartment contains only one size and kind. The smaller compartments may, if desired, hold cutting and rounding needles. The lid is now clamped on and the entire box placed in the sterilizer alongside the instruments. At the conclusion of sterilization the water is drained off, the cover removed and the uncovered container placed on the instrument table ready for use. Used catgut may be replaced and the basin resterilized.

The advantages, as we have found them, are:

1. Provision is made for a protective, almost indestructible, sterilizable container, separating the various sizes and kinds of tube catgut in general use.

2. The full container can be placed in the instrument sterilizer between operations with other metal instruments without danger of breaking the glass tubes or of disturbing their division.



3. It does away with the method in use in some operating rooms whereby one batch of catgut is kept exposed on the "clean" table throughout an entire program of operations.

4. Time may be saved in setting up a room for emergency operations by having this basin filled at all times and ready to be sterilized with other instruments.

Health as freedom from disease is a standard of mediocrity; health as a quality of life is a standard of inspiration and increasing achievement.—*Williams.*

NEW GAS-ETHER ANESTHETIC APPARATUS

A new gas-ether inhaler for administering gas-oxygen, ethylene and ether anesthetics has been devised by Mr. L. A. Sanders, anesthetist, Baylor Hospital, Dallas, Texas. The new inhaler is of the Flagg type with adjustable features added, and consists of a transparent face piece fitted with a close-fitting face cushion, an airway which has a sliding window, and an exhaling valve, and a "T" joint. The "T" shaped joint is equipped with a dripping cup or either which is dropped into the chamber upon a wire screen where it is evaporated.

There are universal joints at two points allowing any position in which it is desired to place the patient, and still have the ether apparatus in a perpendicular position. The instrument is light in weight, making it easy to hold through a long anesthetic without tiring the operator. Any depth of anesthesia can quickly be reached and maintained with this appliance, and an early recovery secured.

Ordinarily the best way to clean marble is to use clean water and clean rags. Under no circumstances should soap be used, because the uncombined fat in soap leaves a slight film on the surface and will ultimately cause a disagreeable yellowish oily appearance to the delicately colored marble. This can be removed by the use of alkali but it is much better to avoid the use of soap so that there will be no cause for discoloration.

FIRE PREVENTION DEPARTMENT

Conducted by W. M. Krieger, Engineer,
209 West Jackson Boulevard, Chicago, Ill.

ARE HOSPITALS PREPARED TO EXTINGUISH SMALL FIRES?

DOES your fire protection meet your present requirements, or is it a haphazard collection of indifferent fire apparatus purchased without a study of your particular needs?

Even if it were adequate for your need a few years ago, the changes which you have been compelled to make in your hospital to keep pace with changing conditions may mean that it is inadequate today to protect you from a disaster, should a fire break out in your property. There are occasions when you can afford to take a chance without risk to yourself or others, but can you afford to trifle with the lives of your patients by taking a chance on the type of fire protection which you provide?

Stop taking a chance. The time to install the fire protection that really protects is before you have a fire.

The Importance of First-Aid Protection

Fire always comes like a thief in the night, seeking what it may destroy. Most fires are the same size at the start. If attacked within the first five minutes with a dependable fire extinguisher they can be put out with but little fire, water or smoke damage. The difference in the amount of damage done by fire, therefore, depends chiefly upon the number of seconds that elapse before one begins to fight the flames with a dependable piece of fire fighting apparatus. Fire is no respecter of persons. It descends alike on the high and the low, the rich and the poor, leaving naught but desolation and ruin, and too frequently death, in its wake.

Civilization has advanced chiefly through the ability of one generation to take advantage of the blunders and poor-sightedness of preceding generations. For centuries fire was regarded as a necessary evil. Today it is preventable.

First-aid medical treatment is often the means of preventing the loss of a patient's life. Likewise, first aid fire protection apparatus is the means of preventing a bad fire loss.

Less than ten minutes' prompt work with first-aid equipment when the fire is young, will generally preserve the fruit of ten years' labor. Watch your newspapers for stories of fires that have been extinguished by the property owner himself by the time the department arrived. Every small fire will be a big one if it gets a chance.

Chemical Extinguishers Most Frequently Used

When we consider that fire departments extinguish, by means of chemical apparatus, more than 80 per cent of the fires to which they are called, the importance of having the chemicals suited to the job is apparent. Soda and acid chemical extinguishers are familiar fixtures on almost all fire trucks. If chemical extinguishers put out 80 per cent of the fires to which the fire department is called, then would it not be better to have an adequate equipment of chemical extinguishers conspicuously placed throughout your hospital for first-aid use?

Fire is the combination of oxygen with any substance heated to a temperature above the burning point. There are only two ways of extinguishing a fire; one is to cool the burning substance below its burning point, and the other is to smother the fire by excluding oxygen. Any fire that is not extinguished by one or the other of these methods or by a combination of both, must burn itself out. Water has been regarded as the most potent fire extinguishing agent, since it can usually be obtained in practically unlimited quantities. It is, however, a slow and, in most cases, an extremely costly method, since water often has to be used in such great quantities that it does more damage than the fire itself.

Water Not Always the Best Extinguisher

Water cools the burning substances below their burning points and has a smothering effect through steam generated when it strikes heated and burning substances. In cases of inflammable liquids, however, the use of water multiplies the danger by spreading the blazing liquid.

Chemical solutions are better than water because, in addition to the water which enters into their composition, they carry carbon dioxide, a fire smothering gas, to the blaze.

Teach Employees to Operate Extinguishers

The two and one-half gallon extinguisher which operates by the action of sulphuric acid upon bicarbonate of soda, is one of the most effective hand extinguishing appliances that can be placed in hospital buildings. Extinguishers of this type which have been tested and approved by the Underwriters' Laboratories should be provided in the corridors of all buildings and also in wards, except where there is danger of their being interfered with by irresponsible patients. Especially should they be provided in all work shops, laundries, kitchens, storerooms and other places of special hazard. All employees should be drilled in the handling of extinguishers.

Extinguishers should be hung where they will be con-

spicuous and easily accessible, with the top not more than five feet above the floor. In one hospital where the only man present was the engineer, the chemical extinguishers were hung so high that it was impossible for any of the women employees to take them down.

Large extinguishers of the soda and acid type, of a capacity from twenty-five to fifty gallons, are mounted on wheels and provided with fifty feet of rubber hose. In the hands of trained men such extinguishers can be used very effectively, even where fires have gained considerable headway. They are especially valuable for large institutions or locations where the water supply is inadequate.

Chemical extinguishers of the soda and acid type should be discharged at least once a year and refilled with fresh chemicals.

Do your employees know how to use an extinguisher? The time to learn is before a fire. A great deal of the effectiveness of an extinguisher lies in its proper use. Instruct your nurses and employees how to use it.

Foam Extinguishers in Oil Fires

Foam extinguishers which smother fires by means of a foam which they generate, are designed especially for the extinguishing of oil fires, but are also effective upon fires in many other materials. A foam type of extinguisher generates approximately eight times the volume of the original solutions used in its production. Carbon dioxide, which is confined in the tough durable bubbles or foam, is distributed quickly and easily over an extensive burning surface of any kind, spreading a blanket of fire-smothering gas directly on the fire and shutting off all oxygen from the flames. The carbon dioxide in the foam type of extinguisher cannot be blown away by the wind or shifted from the fire by drafts. The foam sticks to anything upon which it has been spread until in the course of time the bubbles break and release the gas. Extinguishers of this type are especially effective on fires involving oil, gasoline, benzol, benzine, kerosene, paint, varnish, grease and inflammable chemicals of every kind.

Carbon Tetrachloride Extinguishers

This type of extinguisher is usually of two or three pints capacity and handles a liquid composed largely of carbon tetrachloride. Extinguishers of this type are especially valuable for use on oil or electrical fires. The liquid is a non-conductor of electricity and, when played upon the fire, forms a heavy gas blanket which excludes the oxygen from the flames. These extinguishers are not recommended for general use upon fires in wood, paper and similar materials, but can be used advantageously in the switch and generator rooms, oil rooms, drug rooms, laboratories, and on motors, ambulances, trucks and pleasure cars.

Water Pails—the Oldest Extinguisher

Pails of water are the oldest, cheapest and best understood of all fire extinguishing agents, but it is difficult for anyone, and especially for a woman or a child, to throw water from a pail for any distance. Therefore, water pails should not be substituted altogether for chemical extinguishers. Water pails should be of twelve quart capacity, painted red and stenciled "For Fire Only." They should be filled with clean water and be inspected regularly. Wherever there is danger of freezing during cold weather the water should be treated with the proper quantity of calcium chloride. In places where a large quantity of water may be needed, it is well to provide one or more casks filled with water, and to place the pails either above or inside of them.

Protection of this sort is easily available to everyone at slight cost, and there is little excuse for such conditions as were found in a hospital recently inspected, which was composed of numerous frame buildings, where not even water pails were provided, and where water was shut off throughout the property at night in order to prevent wasting.

Dry Powder Tubes

Metal tubes filled with bicarbonate of soda are found in many of the older hospital buildings and are practically valueless and should be discarded. Bicarbonate of soda has only slightly greater extinguishing value than ordinary dirt, sand, flour or other finely divided incombustible material which can be used to smother flames. At the start of the Iroquois Theater fire, in Chicago, an attendant wasted time in endeavoring to use a dry powder extinguisher to the extent that 600 lives were lost.

Sand Pails for Oil Equipment

Pails of clean, dry sand should be provided where there is danger of fire in oil or electrical equipment, and should be equipped with scoops for scattering the sand. Sand should not be used, however, upon motors or other machinery, because of injury to bearings.

Hand Grenade Extinguishers

Hand grenades or bottles filled with water or special extinguishing liquids are of little value and, like the dry-powder tube extinguishers, they should be discarded, wherever found.

Inside Hose Protection

For fires discovered in the incipient stage, chemical extinguishers, water pails and similar equipment are generally adequate. On buildings of ordinary construction when fires have gained any considerable headway powerful streams from outside hydrants alone will be effective. Between these two stages there is occasionally a time when inside hose equipment proves very useful.

There are, however, several arguments against the use of inside hose in hospital buildings, chief among which is the fact that when fire has gained sufficient headway to require the use of hose it is time for everyone except the experienced firemen to be engaged in getting patients out of the building.

Even where inside hose is provided, its efficiency is frequently lessened by the manner in which it is installed and maintained. Hose hung over pipe connections in a tangled manner, or otherwise not quickly available for use, nozzles missing, and hose wet because of leaking valves, are conditions frequently found. Unlined linen hose rots quickly when wet, and such hose should never be used except in case of fire. Inspection should be relied upon to determine its condition.

Where inside hose protection is installed the water supply and piping should be sufficient to give at least twenty-five pounds pressure at the highest point, and hose should be so located that every point inside the building can be reached by one or more streams.

The importance of equipping every hospital with reliable first-aid fire extinguishing apparatus cannot be emphasized too strongly. If adequate first-aid fire protection is warranted in our factories, warehouses and stores, where daylight is used and physically fit occupants are housed, how much more necessary is fire protection in institutions which are used twenty-four hours of each day in the year, and filled largely with the helpless sick?

COLGATE & COMPANY

deeply appreciates the professional approval, which, increasingly year after year, has been accorded to Ribbon Dental Cream.

In case you have not yet received The Bunzell Research Bulletins Nos. 1, 2, 3 and 4, we will be glad to mail copies on request.

MEDICAL DEPT.
COLGATE & CO.
199 Fulton St., New York

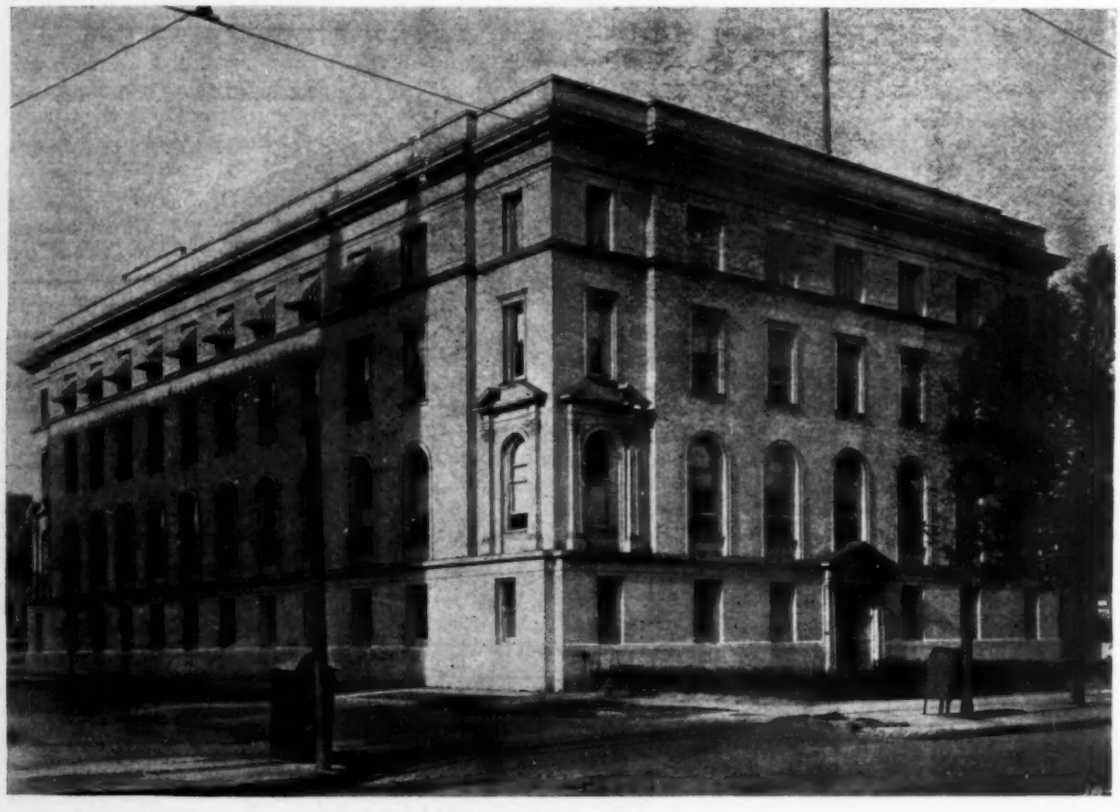
DISPENSARIES AND OUT-PATIENT DEPARTMENTS

Conducted by MICHAEL M. DAVIS, JR., Ph.D., Executive Secretary, Committee on Dispensary Development, United Hospital Fund of New York, 15 W. 43rd Street, New York
and by ALEC N. THOMSON, M.D., Medical Secretary, Committee on Dispensary Development, United Hospital Fund of New York, 370 Seventh Avenue, New York

CONSTRUCTION FEATURES OF THE CLEVELAND CLINIC

THE extension of the plan of group medical practice and the consequent need of buildings especially adapted to this purpose make it appear fitting that plans of existing clinic buildings be published and the salient features of each emphasized for the information of those who may be planning the construction of such buildings.

The founders of the Cleveland Clinic had the great advantage of securing for their architect, Mr. Ellerbe of St. Paul, an architect of broad experience in hospital and clinic construction. The Cleveland Clinic building became in effect a memorial to Mr. Ellerbe who died suddenly very shortly after its completion,—in fact, he never saw the clinic in operation within its walls and it is a fitting tribute to his wisdom in making the plans that the only changes which have been made or desired have been those necessary for expansion.



The Cleveland Clinic.

Exterior of Mottled White Brick

The exterior of the building is of mottled white equitable brick. The walls within are finished in a light buff and the rooms in light gray; the woodwork throughout is of birch. The reception room which occupies the center of the second floor and rises to the skylight is finished in buff Rookwood tile. The examining rooms and offices of the three upper floors are grouped around this well.

From the entrance to the building a corridor leads directly to the registration desk back of which is the

Adv. page 46

288 Servings
from a one-pound package

AFTER purity and wholesomeness, the most important factor in the hospital dietary is **Economy.**

Knox Sparkling Gelatine is supreme for purity and for health promotion.

Every pound package of Knox Sparkling Gelatine will make 288 liberal portions of desserts or salads, or four times more than ready-flavored and artificially colored gelatine.

With Knox Sparkling Gelatine, surplus fruit juices and vegetables, otherwise wasted, may be utilized in the making of beneficial and delicious dishes for many dietetic requirements.

When added to milk, 1% of Knox Sparkling Gelatine (dissolved) will, because of its protective colloidal ability, **increase the obtainable nourishment** by about 23%.

Every hospital kitchen should have the new book of dietetic recipes for Diabetes, Nephritis, High Blood Pressure, Gastritis, Fevers, Obesity, as well as for invalids, convalescents, and children.

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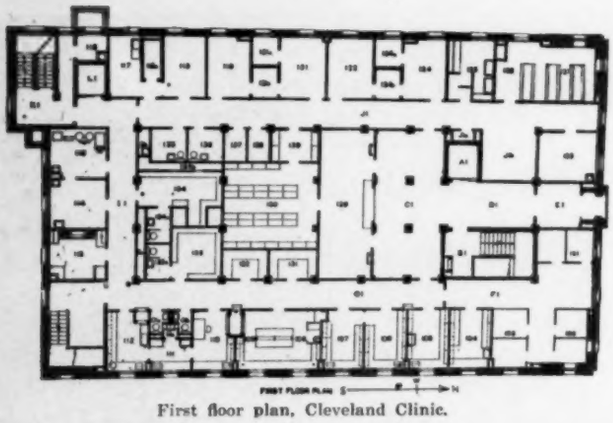
GELATINE

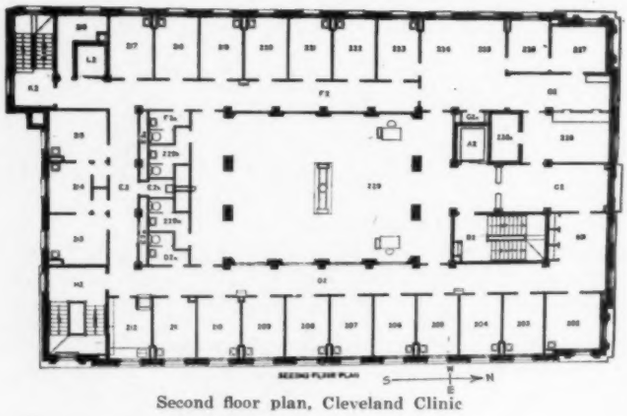
"The Highest Quality for Health"

In addition to the family size packages of "Plain Sparkling" and "Sparkling Acidulated" (which latter contains a special envelope of lemon flavoring), Knox Sparkling Gelatine is put up in 1 and 5-pound cartons for special hospital use. A trial package at 80c the pound will be sent upon request.

Charles B. Knox Gelatine Laboratories, 400 Knox Ave., Johnstown, N. Y.



First floor plan, Cleveland Clinic.

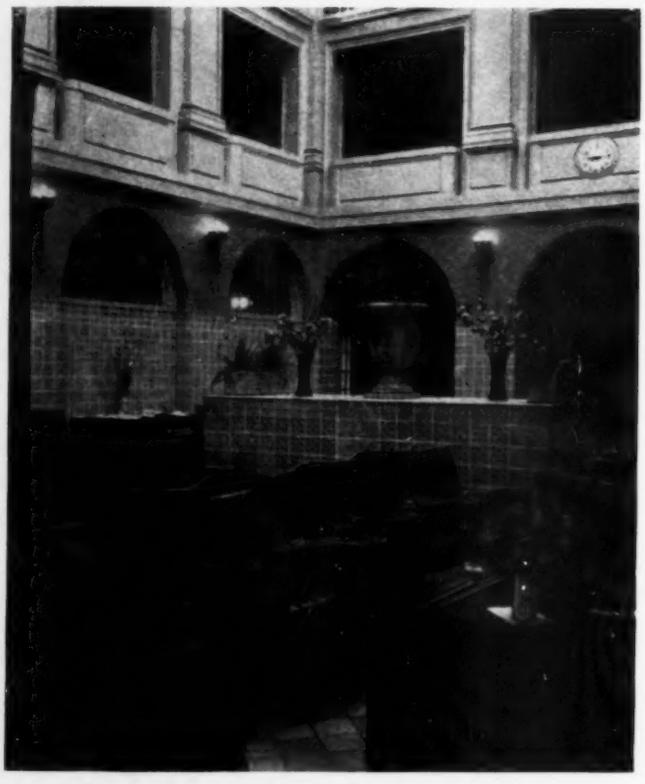


Second floor plan, Cleveland Clinic

record filing room. Small lifts are provided to carry the records from the record room to the desks in the reception room and to the upper floors.

The entire west side of the first floor is devoted to the x-ray laboratories, which include a viewing room, a developing room, fluoroscopic rooms, dressing rooms and lavatories, a waiting room and an office.

On the south end of the first floor is the sterilizing room and adjoining it a small operating room for minor operations and dressings. The entire east side of the first floor with the exception of a section devoted to the work of the statistical department, is occupied by the pharmacy and the clinical laboratories including rest rooms and rooms for gastric analysis, serologic, bacteriologic, pathologic, chemical and other clinical investigations.



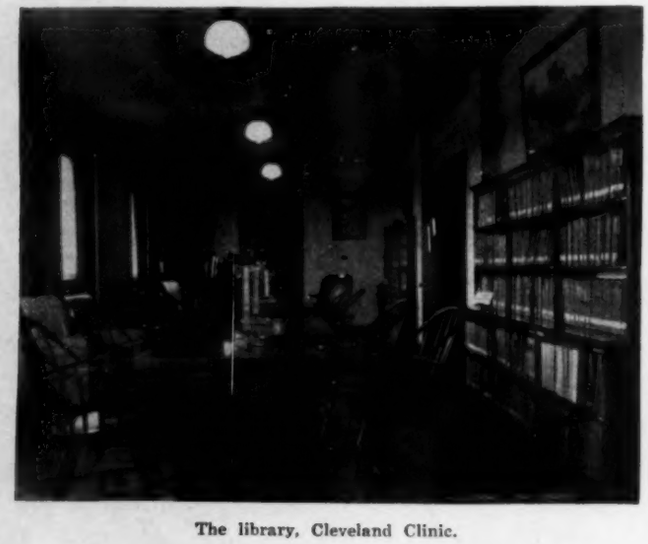
Entrance and registration desk, Cleveland Clinic.

On the east and west sides of the second floor are consulting rooms and the financial department, with the telephone switchboard on the north side. On the south side are the cystoscopic rooms. Viewing boxes for the examination of x-ray plates are located in the corridors.

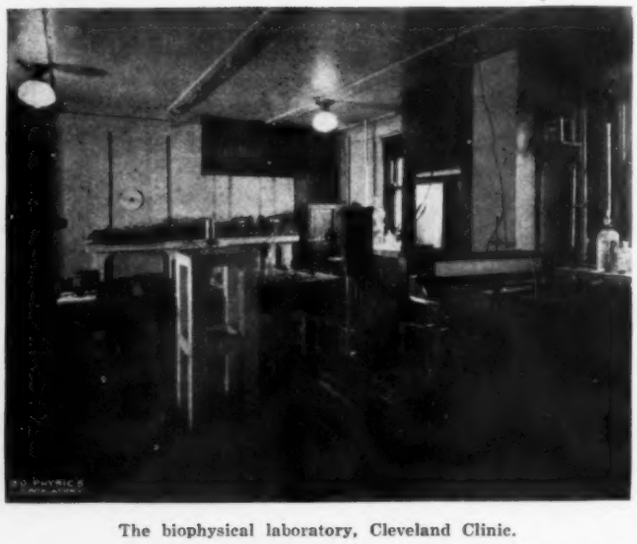
The reception room on the second floor of the building forms the heart of the building.

On the third floor the rooms arranged around the well, formed by the reception room, include offices equipped for the work of various special departments,—dentistry, orthopedics and physiotherapy, dermatology, electrocardiograph and basal metabolism.

On the fourth floor are three special departments,—otolaryngology, neuro-



The library, Cleveland Clinic.



The biophysical laboratory, Cleveland Clinic.

Adv. page 48

Delicious!

JELL-O is the ideal food for the invalid and the convalescent. It is most tempting, with clear, sparkling color, very wholesome and easily digested.

A test of Jell-O reveals 85.8 per cent. carbohydrates, 12. 2 per cent. protein, 2 per cent. pure vegetable acid, and yields a high food value.

Jell-O may be served plain, or, if the patient's condition permits, with fruits, nuts, or whipped cream.

And for hospitals and other large institutions the Institutional package is most convenient and economical. Its contents makes one gallon of Jell-O, enough for forty to fifty persons.

Institutional Size
makes one gallon

JELL-O

America's Most Famous Dessert

THE JELL-O COMPANY, Inc., LE ROY, NEW YORK

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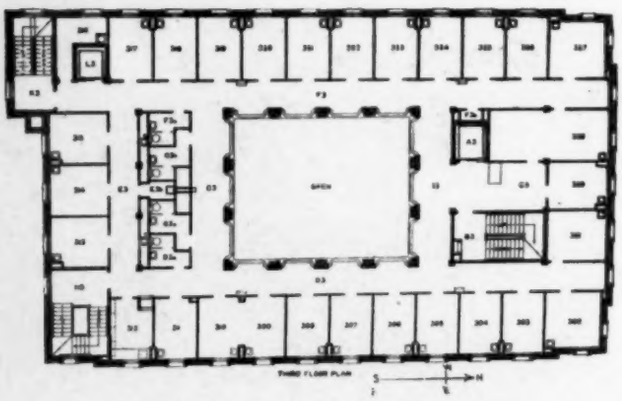
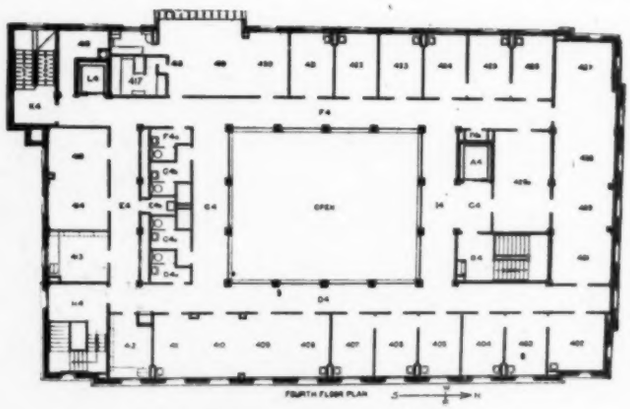


Third floor plan, Cleveland Clinic.



Fourth floor plan, Cleveland Clinic.

surgery and ophthalmology, —the founders' conference room, the executive offices, the library with its stack room, the editorial offices, and the art department. The department of biophysics occupies a large laboratory on the south side and an office on the west side of this floor.

On the roof at the south end, is the electro-mechanical engineering department where apparatus for new projects and for research work is designed and made.

The building has three stairways and two elevators. Clinical laboratories at the southeast corners of the second and third floors are connected with the main clinical laboratory on the first floor by a small hand elevator.

Immediately associated with the clinic in a neighboring house is an especially equipped department for deep x-ray and radium therapy, and a hospital with accommodations for 150 patients.

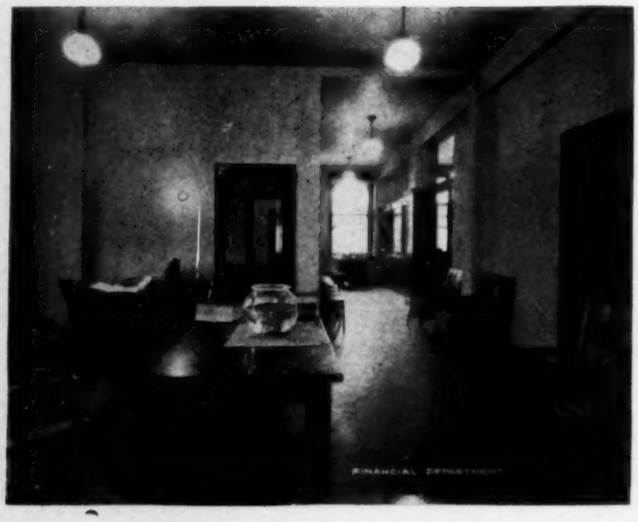
[Additional pictures of the Cleveland Clinic will be found on the top of page 84. —Ed.]

Portion of biochemical laboratory, Cleveland Clinic.

CONSULTANT IS APPOINTED

Miss Elizabeth F. Miller, R. N., formerly of Philadelphia, and president of the Pennsylvania State League of Nursing Education, has been appointed as the nursing consultant of the department of welfare.

Her services are to be devoted to the development and standardization of nursing service and nurses and attendants training schools in the state-owned mental hospitals and the state-owned general hospitals in the anthracite coal field.



Financial department, Cleveland Clinic.

Founders conference room, Cleveland Clinic.

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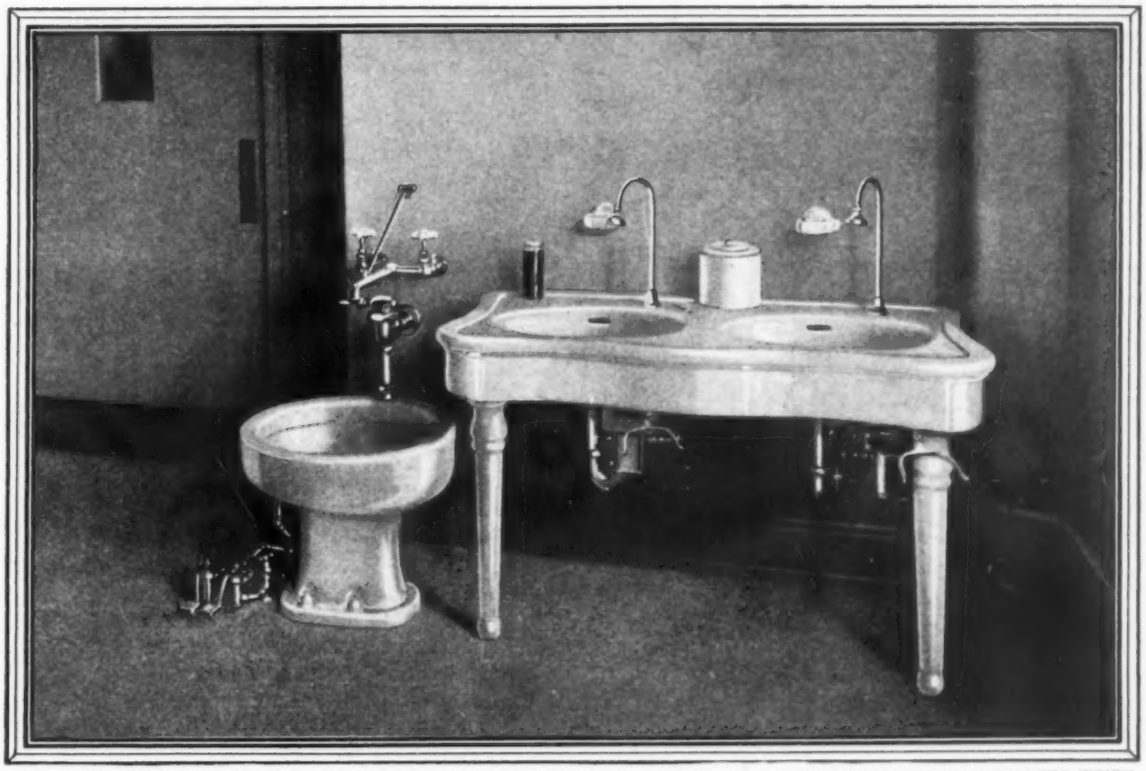

CRANE SURGEON'S LAVATORY OF SOLID PORCELAIN AND CLINIC SLOP SINK, IN METHODIST HOSPITAL, MEMPHIS, TENN.
W. F. SCHULZ, ARCHITECT AND ENGINEER. J. W. HULL PLUMBING AND HEATING COMPANY, CONTRACTORS

IN CHOOSING PLUMBING, MAKE SURE OF LASTING QUALITY

You never need to buy hospital plumbing blindly. Even if you made your last purchase years ago, when the refinement of modern fixtures was unknown, you can be certain of choosing correctly. The experience of others will guide you.

No matter where your institution is located, somewhere near you is an installation of Crane hospital plumbing. Large or small, special or general, every Crane-equipped hospital is at once an indorsement of Crane lasting quality and a safe guide to follow.

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Methodist Hospital, Memphis, Tenn.

The electromechanical engineering department, Cleveland Clinic.

The art department, Cleveland Clinic.

RECORD FORMS FOR CLINICS TREATING SYPHILIS AND GONORRHEA*

REPORT OF THE COMMITTEE ON RECORDS OF THE VENEREAL DISEASE SECTION OF THE ASSOCIATED OUT-PATIENT CLINICS OF THE CITY OF NEW YORK

FOR convenience in reference the committee summarized the general recommendations as to "Principles and Forms for Out-Patient Records," as follows:

The forms agreed upon by the committee on records of the administrative section, which is composed of hospital superintendents, includes: admission card, index card, transfer and refer forms, abstract form, and the administrative items on history face and continuation sheets. These latter include: the name of the institution, name of patient, address, history number, date of admission, clinic, sex, marital condition, age, and exact occupation.

A good quality of paper is recommended for the history sheet as being preferable to cards in that the paper allows for typing, and single sheets are preferable to double as being sufficient in the majority of cases; the size of the sheet should be the same as that of the hospital record preferably eight and one-half by eleven inches. In general, in determining size of forms, consideration should be given to dimensions of standard file drawers and also to the sizes of paper and card stock in order to avoid waste in cutting. Forms should be filled out in typewriting so far as possible.

On many history sheets the space below the administrative items is left blank for writing in the medical history and examination findings, in narrative form. This allows for freer notation of insignificant conditions which are somewhat out of the ordinary and would not be apt to appear on a printed outline unless this were so exhaustive as to be cumbersome. The difficulty with detailed printed history forms is that they consume space, and often there are no positive findings to enter after a majority of the items. Where itemized sheets are not used it is advisable to supply, for the guidance of the physician, outlines of the points which must be covered in the examination of each patient. These outlines should be kept in a convenient place for reference, but should not be incorporated in the history forms.

With these findings the committee on records of the venereal disease section concurs and strongly recommends the systematizing of record keeping in out-patient departments to the end that, wherever possible, one form will be used for all clinics. This form should bear merely the administrative items, the remainder of the sheet being left blank for examination findings and other notes.

In a department treating syphilis it is felt that the general institution face sheet can be used for recording history and physical findings if there is a suitable schedule of procedure provided as a guide to the physician. The following is suggested for this purpose.

Guide Sheet

1. *General.* (a) In taking the history of a syphilitic,

Committee on Records' Report

THE committee on records of the section on administration of the associated out-patient clinics, whose report was published in the August, September and October issues of THE MODERN HOSPITAL, was concerned chiefly with those factors of forms essential to the proper conducting of an out-patient department, particularly those necessary for identification, placing and supervision of individual patients, rather than with the professional content of the records. The committee therefore asked that other sections be requested to consider record forms from the standpoint of the content of their various branches of medical service. The section on venereal diseases has forwarded the accompanying recommendations to the general committee on records.

*See "Principles and Forms for Out-Patient Records" in THE MODERN HOSPITAL, August, September and October, 1924.

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Are you overlooking this opportunity to build *good will?*

Skillful surgeons and physicians, competent nurses, good equipment—these make your institution a blessing in your community. But in the re-told stories of every discharged patient one thing else is always mentioned. Sometimes it is the deciding factor in one hospital's favor over another. The quality of the food.

Of course, the foods you serve are wholesome. But patients expect that; they judge your foods by their *tastiness.* Serve more tempting dishes finer-flavored dishes, and you may be sure that the news will soon spread throughout your community.

You can now secure a wide variety of foods as distinctive in their goodness as Libby's Pineapple and Libby's Asparagus. Foods which, like these, are packed with unusual care right at the spot where they are found at their finest. And you can always depend upon these products; their quality never varies.

Libby Foods are not expensive. You can get them in the quantities you need, and when you want them! Notice the partial list below. Which ones would you like to try? Tell our nearest branch.

Libby, McNeill & Libby
1901 Welfare Bldg., Chicago

'Phone or write the Libby branch nearest you. You will find that Libby service matches Libby quality

Albany, N. Y., 109-11 Montgomery St.
Atlanta, Ga., 110 Peters St.
Baltimore, Md., 105 Cheapside St.
Boston, Mass., 52 Eastern Ave.
Buffalo, N. Y., 202 Perry St.
Chatham, Ont., Canada, 330 Richmond St.
Denver, Colo., 1738 Wynkoop St.
Detroit, Mich., 212 New Telegraph Bldg.
El Paso, Texas, 403-5 E. Main St.
Ft. Worth, Texas, Ft. Worth Stock Yards
Hartford, Conn., 301 Pleasant St.
Houston, Texas, 1213 N. Main St.
Jacksonville, Fla., Union Terminal Bldg.
Kansas City, Mo., 1522-24 St. Louis Ave.
Los Angeles, Calif., 825-7 Alameda St.
Memphis, Tenn., 693-9 S. Main St.
Minnesota Transfer, Minn., Care of Central Wholesale Co.
Montreal, Que., Canada, 645 St. Paul St., W.
New Orleans, La., 514-6 Tchoupitoulas St.
New York, N. Y., 605 W. 27th St.
Norfolk, Va., 517 Front St.
Oklahoma City, Okla., 319 E. Grand Ave.
Philadelphia, Pa., 5th & Willow Sts.
Pittsburgh, Pa., 209 Ferry St.
Portland, Me., 253 Commercial St.
Portland, Ore., 41 Front St.,
Salt Lake City, Utah, 404 Vermont Bldg.
San Francisco, Calif., 132 Pacific St.,
St. Louis, Mo., 206-10 S. 7th St.
St. Johns, Newfoundland, 158 Duckworth St.
Savannah, Ga., 565 W. Hull St.
Seattle, Wash., 225-7 Jackson St.
Toronto, Ont., Canada, 32 Front St., W.
Vancouver, B. C., Canada, 1100 Hamilton St.
Winnipeg, Man., Canada, 260 Princess St.

Libby's FOODS

These Libby Foods of finest flavor are now packed in special sizes for institutions

Corned Beef
Sliced Dried Beef
Bouillon Cubes
Beef Extract
Chili Sauce
Catchup
Sweet Relish
Olives
Pickles
Sweet Mixed Pickles
Evaporated Milk
Hawaiian Pineapple
Plum Pudding
California Fruits
Asparagus
Spinach
Kraut
Jellies and Jams
Pork and Beans
Mince Meat

certain features as indicated below, must be inquired into. (b) Only the positive findings need be recorded. (c) Give the patient the printed instructions about syphilis; see that he understands them.

2. *Family history.* Inquire specifically into the following details about father, mother, brothers and sisters: (a) Age and health, if living; or age at death and cause of death; and constitutional diseases. State the age of the relative immediately after the name. After the age state whether "well," "ailing," "sick" or "dead," followed by disease or cause of death. To indicate the number of brothers and sisters, the numeral may be used immediately before the name. Example:

Father, 72, ailing, rheumatism; mother, 54, dead, tuberculosis; 3 sisters, 17, 24, 26, all well; 2 brothers, 19, well, 21, tuberculosis. (b) Syphilis in all near relatives is to be asked about and recorded, if present.

3. *Marital history.* (a) If patient is married, state how long. Give the number of full-term children, stillbirths, miscarriages; specify the relative order of the pregnancies so terminating. If patient is a male, enter this information in regard to his wife.

(b) State ages and health of living children and causes of death of those not living, according to method illustrated above.

(c) Ask for specific symptoms of syphilis in children.

4. *Previous personal history.* Presence of venereal sores, single or multiple, relation to coitus; kind of treatment, time required for healing; presence of bubo; appearance of secondaries; previous serious illnesses. Menstrual history of women patients, particularly in regard to a possible present pregnancy.

5. *Present history.* Enter the facts in the following order:

(a) Primary lesion; Time of appearance; incubation; location; character; duration; treatment.

(b) Secondary stage, location and time of appearance after primary of the following: rash; mucous patches; condylomata; alopecia; bone pains; neuritis; iritis; deafness; etc.; presence of any constitutional symptoms; anemia; anorexia; emaciation; fever.

(c) Tertiary stage: presence of gummata; location; time of appearance; duration. Inquire carefully for the following: lancinating pains anywhere and especially in lower extremities; analgesia; hyperesthesia; paraesthesia; loss of control of bladder or rectum; girdle pains; felt-like sensation in soles; visual disturbances; impotence; ataxia; evidence of loss of mental power, as ethical decline, defective recording faculty, defective memory for recent events, inability to concentrate, abnormal irritability, delusions of grandeur, etc.

(d) Give a summary of the treatment received, indicating when, in relation to any manifestations of the disease, it was taken. Outline results of treatment.

6. *General examination.* Make your examination thorough. Do a "complete physical." Have the patient strip.

(a) In all cases note: height, weight, nutrition, condition of teeth and mouth, examination of urine.

(b) In cases presenting pathological findings, enter the following:

General points: Gait, attitude, posture, build, musculature; mental state; skin—color, thickness, transparency, moisture, eruption, edema, pigmentation, scars, striae, dilated veins, pulsating vessels; body temperature; bones; joints; radial pulse on both sides; blood pressure.

Examination of: head, chest, abdomen, extremities.

7. *Specific examination.* Enter the positive findings in the following order:

(a) Primary lesion: location, general characteristics, etc.

(b) Secondary lesions: rash, mucous patches, condylomata, alopecia, adenopathy.

(c) Tertiary lesions: gummata, location, etc.

(d) Involvement of the nervous system: Argyll-Robertson pupils, anisocoria, occular palsies, other cranial nerve palsies. Spinal reflexes. superficial and deep, especially the knee and ankle jerks, syllable stumbling, paralyses, local and systemic, etc.

Record of Visits

The committee feels that there are obvious advantages in recording in columnar form such routine procedures as the revisits of syphilitic patients. It therefore suggests for this purpose the following heading printed on special sheets:

Syphilis

Date	Medication—Dose			Laboratory Findings	Progress Notes and Remarks
	As.	Hg.	K I		

Gonorrhea

Dealing with the problem of gonorrhea, there are certain steps which must be followed in the examination of every case, either male or female. It is the opinion of the committee on records of the venereal disease section that a printed form is essential in order to insure logical sequence. It would be possible to use a rubber stamp for the purpose of imprinting such an outline on the general institution face sheet, although the printed form is preferable where it is justified by the volume of work in the clinic. The accompanying forms A and B, for male and female patients are suggested for printing.

Institutional heading—standard identifying and administrative data

1. Family history
2. Marital history
3. Previous personal history
4. Present history
5. Examination

Date when first made

General appearance
Prepuce
Glands
Meatus
Smear
Inguinal glands
Scrotum
Urine 1
Urine 2
Prostate

Vesicles

Expression smear
Urethra bougie

Endoscope

Form A. Record form for male patient with gonorrhea.

Guide sheet. It is advisable here, as with the syphilis clinic, to supply the examining physician with a guide sheet. This can be similar to the one recommended for

Adv. page 54

FAITH

Faith in Religion—in American institutions—their ideals, spurs us on to greater achievements.

Faith in others—to recognize superior quality and workmanship—to appreciate the true value of *Good Glass Service* makes us strive to supply at all times *Glassware of Service.*

HAZEL-ATLAS TUMBLERS have that smooth finished edge, clear color, sparkling polish and smooth bottoms.

OUR H MONOGRAM guarantees highest quality and lowest prices.

Sold only through merchants.

Ask your supply house for samples and prices.

HAZEL-ATLAS GLASS CO.

WHEELING, W. VA.

Examination

Date when first made

General appearance
Pudenda
Vagina

Vulv. vag. glands
Smear

Cervix
Discharge
Smear

Urethra
Skene's glands
Smear

Anus
Inguinal glands

Endoscope

Form B. Examination record form for female patient with gonorrhea to follow points 1 to 4 as in Form A.

a syphilis clinic as to the introductory paragraph, family history and marital history, substituting the word "gonorrhea" wherever "syphilis" occurs.

It is essential that the guide sheet for history taking and examination for gonorrhea cases should go into detail with regard to the location, character, periodicity and other factors of pain, discharge and the like, as well as whether the patient has been undertreated, overtreated, or conservatively treated.

It is suggested that a similar arrangement can be followed for examination of the female gonorrheal patient, and in one instance, at least, the two have been combined and this may be the most practical procedure where the clinic treats gonorrhea in both the male and female. The accompanying Form B is suggested for recording the examination of the female, following the first four items, which are the same for both.

In the routine handling of revisits of gonorrheal patients, there are certain observations which need to be recorded with considerable frequency and in a definite order. To do this economically the committee recommends a printed columnar arrangement as follows:

GONORRHEA (MALE)

Date	Discharge	Time since last urination	Meatus	Smear	Urine 1	Urine 2	Remarks	Treatment

GONORRHEA (FEMALE)

Date	Discharge	Urethra	Vagina	Cervix	Urine	Remarks	Treatment

THE PLACE OF EDIBLE GELATIN IN GENERAL AND SPECIAL DIETS

(*Continued from page 66*)

other wasting diseases, gelatin as a protein may possess a value similar to that found in diabetes.

Relative to tuberculosis patients, Hawk reports that fifty patients were given gelatin in addition to their regular egg-milk diet and that thirty-five of them showed definite improvement. In most of the other cases intestinal ulcerations and other complications existed. He concluded that the beneficial effects noted were due largely to the better utilization of milk. It is interesting to note that the author in a feeding test with rats has found that a more efficient utilization of milk-egg (one egg to a quart of whole milk) is secured by the inclusion of one per cent of gelatin.

Gelatin as an Aid to Digestion of Foods

For general convalescents and invalids, gelatin as such, and the partially digested protein gelatin peptone, are desirable dietary adjuncts. For dysphogic conditions gelatin jellies afford ready means for the ingestion of foods with minimum discomfort to the patients. As a dessert in training diets, the use of gelatin has been commended. For persons afflicted with various stomach disorders, gelatin may be of value. Gelatin is readily digested by individuals showing either hypo- or hyper-acidity, and it may be of material benefit as a vehicle and aid to the digestion of other foods.

Finally, in preparing foods for the sick, the appearance and taste of the resultant preparations should not be left to chance. Gelatin desserts afford a pleasing variety. Also, gelatin has been found to be unexcelled as a vehicle for carrying other foods; it confers upon them an added brilliance of appearance and permits a wide range of flavors. It often occurs that certain foods become obnoxious to patients when served alone, but are perfectly acceptable to them when combined with gelatin.

It is apparent from this discussion that gelatin is a valuable component of general dietaries and may be of even greater utility in special dietaries. Its place is primarily that of a carrier of other foods, enhancing their attractive appearance and improving their nutritive values by its supplementary value as a protein and by its colloidal properties.

NEW YORK DIETITIANS HOLD DECEMBER MEETING

The New York Association of Dietitians met in the clinic lecture room of the Presbyterian Hospital, New York, N. Y., December 15. The chief speaker of the evening was Dr. Walter Palmer, professor of medicine, Columbia University Medical School and director of medical service, Presbyterian Hospital. In his discussion of recent advances in nutrition, Dr. Palmer dwelt particularly on milk in various forms for children and the vitamines, including vitamines D and X. The treatment of diabetes was mentioned briefly. Further discussion of this paper was led by Mrs. Mary de Garmo Bryan. Other features of the program included a short explanation of the main points of the Pirquet System by Miss Lulu Graves and a resume of what knowledge of nutrition the student dietitian should have, by Miss Margaret Brown, Inglewood, New Zealand who will shortly finish student dietitian training at Mt. Sinai Hospital, New York, N. Y.

Miss Enid Gibbard, formerly of St. Luke's Hospital, Chicago, Ill., has gone to Mercy Hospital as chief dietitian.

Adv. page 56

The Hospital and Acidosis

THE community health protection given by the hospital and its outpatient department, may well include education of the public toward the prevention as well as the correction of acidosis.

Acidosis is a forerunner of so many serious organic troubles that its correction or prevention comes naturally within the field of the health protection service which today is generally accepted as a part of the hospital's function. Furthermore acidosis becomes more particularly a problem of the hospital because so frequently the condition is recognized for the first time when the patient enters the institution for diagnosis and treatment of some other ailment.

Whatever may be the underlying cause the simple corrective treatment here discussed should be considered by those responsible for the treatment and care of patients in hospitals and similar institutions.

The increasing use of sodium bicarbonate by the public to control "acid stomach" should be considered in this connection. Only a part of the bicarbonate is effective and that portion which produces carbon dioxide may be seriously detrimental.

Phillips' Milk of Magnesia being free from carbonates does not distend the stomach nor cause flatulence of the lower intestinal tract. Its antacid action is pronounced. A given quantity of Phillips' Milk of Magnesia neutralizes almost three times as much acid as a saturated solution of sodium bicarbonate and nearly fifty times as much as lime water. Further it has the additional merit of being laxative, a quality of importance here since constipation is so frequently the underlying cause of hyperacidity.

DOSAGE

The usual dose of Phillips' Milk of Magnesia, as an antacid, ranges from one teaspoonful (4 c. c.) to one tablespoonful (16 c. c.). This amount should be mixed with an equal portion of cold water or milk and given half an hour after meals.

For its laxative effect, the adult dose is one to two fluid ounces (30 to 60 c. c.). The aperient action may be facilitated by giving the juice of lemon, lime or orange, half an hour thereafter.

PHILLIPS' Milk of Magnesia

CAUTION. Beware of imitations of Phillips' Milk of Magnesia. The genuine product bears our registered trade-mark. Kindly prescribe in original 4-ounce (25c bottles) and 12-ounce (50c bottles) obtainable from druggists everywhere.

Prepared only by

The Charles H. Phillips Chemical Co., New York and London

When using advertisements see Classified Index, also refer to YEAR BOOK.

OCCUPATIONAL THERAPY AND REHABILITATION

Conducted by LOUIS J. HAAS, Director of Men's Therapeutic Occupations, Bloomingdale Hospital, White Plains, N. Y., and MRS. CARL HENRY DAVIS, Advisor in Occupational Therapy, 825 Lake Drive, Milwaukee, Wis.

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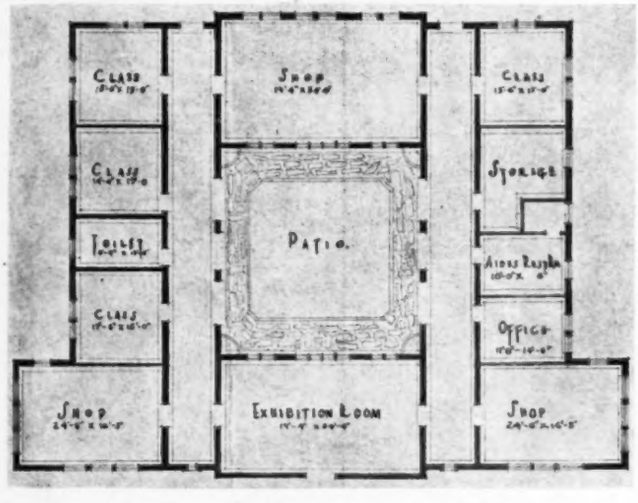
OCCUPATIONAL THERAPY IN THE U. S. VETERANS' BUREAU HOSPITALS

BY B. W. CARR, M.D., CHIEF, OCCUPATIONAL THERAPY, U. S. VETERANS' BUREAU, WASHINGTON, D. C.

IT is impossible to fix definitely in history the time or place where work was first used in the treatment of disease. Records are extant which show that near the end of the eighteenth century consideration was being given to this subject, both in this country and abroad. Dunton[1] finds an account dated 1791 of a Scotch farmer who acquired great fame for his success in the treatment of insanity. He compelled his patients to work on his farm, varying their occupations, and assigning to each the task he was best qualified to perform.

During the years that followed, there appear in this country occasional instances where some person or institution made use of occupations as treatment, but there was no concerted use of occupational therapy during the nineteenth century. Early in the present century, however, there was a renewal of interest in this subject, and at various centers investigations were begun which laid the foundation of modern occupational therapy, but it was only when the army hospitals were preparing to receive large numbers of disabled soldiers that this form of therapy was systematically developed on a broad scale.

The hospitalized beneficiaries of the U. S. Veterans' Bureau, at the present time, consist principally of men with tuberculosis, those with some neuropsychiatric disability, and those who are suffering temporary recession in their physical condition due to wounds incurred in service. The last class is usually hospitalized for comparatively short periods, but the patients in the tuberculosis and neuropsychiatric hospitals must, from the nature of their complaints, be wards of the government for extended periods. Where patients must remain in the hospitals for months or even years they will, of necessity, have much spare time, and the use of this time has a very definite bearing on their progress. Occupational therapy is utilized to counteract some of the dangers engendered by idleness and at the same time to serve as a constructive factor from the therapeutic and economic standpoints during hospitalization.



Occupational therapy building, U. S. Veteran's Hospital, Livermore, Cal.

DAILY REPORT OF OCCUPATIONAL AIDE

UNITED STATES VETERANS BUREAU

Station ..... *Month of* ....., 192

No.	PATIENT'S NAME	DAILY ATTENDANCE 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31	TOTAL HOURS	RATING	PROJECT
1					
2					
20					

THIS RECORD IS TO BE MADE OUT DAILY BY EACH AIDE BEFORE CHECKING OUT. IT MUST REMAIN IN OCCUPATIONAL THERAPY FILE.

"E," entered; "L," left; "A," absent; "Ex," excused absence. Attendance should be designated in hours and half hours, and entered in date columns opposite patient's name. Rating shall be indicated by number: 1, excellent; 2, good; 3, fair; 4, poor. A summary of this report will be transferred each month to the patient's clinical record.

Signed .....

Figure 1.

1. Dunton, Jr., W. R., M. D., Reconstruction Therapy, Saunders, 1919.

Adv. page 58

Where will you draw the line?

IF ONE of your patients were suffering from a marked condition of hypertension with some cardiac involvement, you would unhesitatingly rule out coffee and tea.

Since there are innumerable gradations between a condition of perfect health and an outstanding condition of disease with marked cardio-vascular involvement, who can say at what point coffee becomes detrimental, or to what extent coffee has contributed to the development of the condition?

At what point will you rule out coffee? Where will you draw the line?

Regarding tea and coffee, which he termed "poisons," Professor Theodore C. Janeway made this statement: "That they may lead to disturbance of the heart's rhythm, to vaso-motor disorders and to marked subjective symptoms is well known. It is possible that permanent lesions in the heart muscle may follow, but evidence is very difficult to obtain."

More than 2,000,000 American families are avoiding caffein's dangerous possibilities by drinking Postum. Many of them dropped a coffee habit of years and quickly learned to like Postum for its own distinctive Postum flavor.

They serve Postum to their children. Instant Postum made with hot (not boiled) milk has all the body-building virtues of wholesome warm milk. It satisfies the child who does not like the taste of milk, or who begs for the drink of the grown-ups.

Thousands of physicians recommend Postum as a satisfying hot beverage that is free of the slightest trace of the drug caffein. Whole wheat and bran, skillfully roasted, with a little sweetening — that is Postum.

POSTUM CEREAL CO., INC., BATTLE CREEK, MICH.

We will be glad to send the physician who addresses us a special gift package containing a full-size package of Instant Postum, together with samples of other Post Health Products.
If you live in Canada, address Canadian Postum Cereal Co., Ltd., 45 Front Street, East, Toronto, Ont.

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Figure 2. **INSTRUCTIONS FOR PREPARING MONTHLY REPORT OF OCCUPATIONAL THERAPY**

In Veterans' Hospitals on the first day of each month this report for the preceding month shall be prepared in duplicate, the original forwarded to Central Office and the copy retained in station file In contract hospitals the report shall be prepared in triplicate, the original forwarded to Central Office, one copy retained for station occupational files, the other copy forwarded to the District Manager.

In making up the personnel portion of the monthly report of occupational therapy it will be noted that eleven (11) main topical activities are listed on the report blank, and also are listed below with classified subtopics indicated. Patients treated and occupied hours will be entered in the spaces indicated.

1. TEXTILES:
   - a. Knitting.
   - b. Knotting.
   - c. Rugs, hooked.
   - d. Weaving.
   - e. Tailoring.
   - f. Plain sewing.

2. REED AND CANE:
   - a. Basketry.
   - b. Chair caning.
   - c. Raffia.
   - d. Rush seating.

3. WOODWORKING.
   - a. Cabinetmaking.
   - b. Carpentry.
   - c. Wood turning.
   - d. Toy making.
   - e. Wood carving.
   - f. Brush making.

4. LEATHER AND BOOKBINDING.
   - a. Leather tooling.
   - b. Leather carving.
   - c. Bookbinding.
   - d. Shoemaking.
   - e. Shoe repairing.

5. CEMENT AND PLASTIC:
   - a. Molding.
   - b. Pottery.
   - c. Cement work.

6. DRAWING AND PAINTING.
   - a. Block printing.
   - b. Designing.
   - c. Drafting.
   - d. Drawing, mechanical
   - e. Show-card coloring.
   - f. Sign painting.
   - g. Stenciling.

7. ACADEMIC.
   - a. Americanization.
   - b. English, advanced.
   - c. English, elementary
   - d. French.
   - e. Geography
   - f. History.
   - g. Latin.
   - h. Mathematics.
   - i. Physics.
   - j. Reading and spelling.
   - k. Science, general.
   - l. Spanish.

8. COMMERCIAL:
   - a. Bookkeeping.
   - b. English, business.
   - c. Mimeograph.
   - d. Multigraph.
   - e. Law, commercial.
   - f. Penmanship.
   - g. Salesmanship.
   - h. Shorthand.
   - i. Spelling.
   - j. Typewriting.

9. AGRICULTURE:
   - a. Animal husbandry
   - b. Bee culture.
   - c Floriculture
   - d. Poultry raising.
   - e Horticulture

10. METAL WORK.
   - a. Automechanics.
   - b Machine shop.
   - c Sheet metal
   - d. Piping
   - e Jewelry
   - f Brass and copper.
   - g. Watch repairing.
   - h. Typewriter repairing.

11 OTHER O. T SUBJECTS.

In column 1, list (1) Occupational Director; (2) occupational therapy personnel—male; (3) occupational therapy personnel—female; (4) stenographer; (5) janitors, messengers, etc. Directly above the name indicate the nature of any absence or other change of status. In column 2 indicate the actual number of days on duty.

In the upper spaces of the subcolumns of main column 3 enter the number of patients receiving treatments in the subjects indicated; and in the lower spaces of the subcolumns of main column 3 enter the total number of occupied hours for each subject. (This is obtained by adding together the number of hours given to each patient in that subject.)

In column 4 indicate the actual number of individual patients treated by each of the occupational therapy personnel.

In column 5 indicate the total number of hours of occupational therapy for each member of the occupational therapy personnel. (This is obtained by adding together the hours indicated in all the subjects of the subcolumns under the main column 3.)

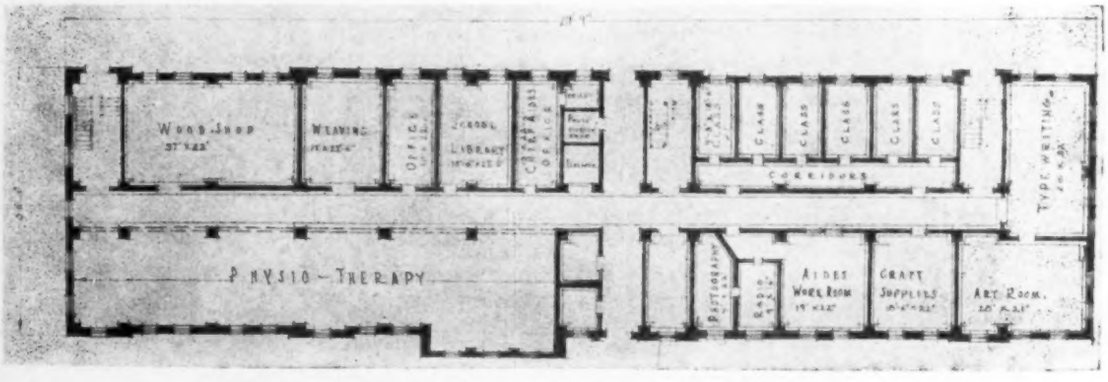
As defined by the Veterans' Bureau, occupational therapy includes any occupation, mental or physical, definitely prescribed and guided for the distinct purpose of contributing to or hastening recovery from disease or injury of claimants of that bureau. This is adopted with but slight change from the definition officially recognized by the American Occupational Therapy Association.

The clause "definitely prescribed and guided" is of particular importance, as the value of occupational therapy is directly proportionate to the care exercised in its administration. Only medical officers are authorized to prescribe occupational therapy, and they are expected to study their cases and to prescribe this measure as carefully as they do any other therapeutic agent.

This form of therapy is administered by trained technicians, designated as occupational therapy aides or instructors. Many of them are graduate occupational therapists, others have special training in some particular occupation, and all are expected to have some knowledge of anatomy, physiology, and other medical subjects. They receive training in hospital ethics, and many of them have had special training in working with mental or with tuberculous cases. The salaries paid vary from $1,680 — $1,740 — $1,800 for the staff aids or instructors to $2,250 — $2,500 for the chiefs who are in charge of the departments.

In prescribing occupational therapy the medical officer fills in the upper half of Form 2614-1 (fig. 4) the clinical record sheet designed for this purpose. The general type of occupation, the periods to be occupied, and and the objective of the treatment are noted.

At the beginning of each month, or whenever the patient first reports to the department, his name is placed by the chief aide on form 2592 (fig. 1), which is given to the aide or instructor. On this sheet the aide keeps a daily record of each case, and at the end of the month these reports are summarized and transferred to the lower part of form 2614-1, which when completed is filed as a part of the permanent clinical record. Also monthly reports of the work of the occupational aides or instructors. Form 2634 (fig. 3) are submitted by the hospitals to the central office at Washington. Thus it is possible to keep a constant check on the field activities.



Occupational therapy building, U. S. Veteran's Bureau Hospital, Oteen, N. C.

Adv. page 60

Peptone Solution (Armour) 5%. Isotonic—Sterile

As an aid in immunization and desensitization. Used hypodermatically in Migraine, asthma and other allergies with satisfactory results.

This Solution is prepared from a special product consisting of primary and secondary proteoses and peptone. It is free from histamin and other toxic substances.

Peptone Solution (Armour) 1 c. c. ampoules, 12 in a box.

PHARMACEUTICAL PRODUCTS

Pituitary Liquid, ½ c. c., 1 c. c. ampoules.
Suprarenalin Solution, 1 oz. g. s. bottles.
Corpus Luteum, true substance.
Thyroids, standardized for iodine content.
Elixir of Enzymes, digestant and vehicle.
Suprarenal Cortex—powder and tablets, free from active principle.

Literature on request

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CHICAGO

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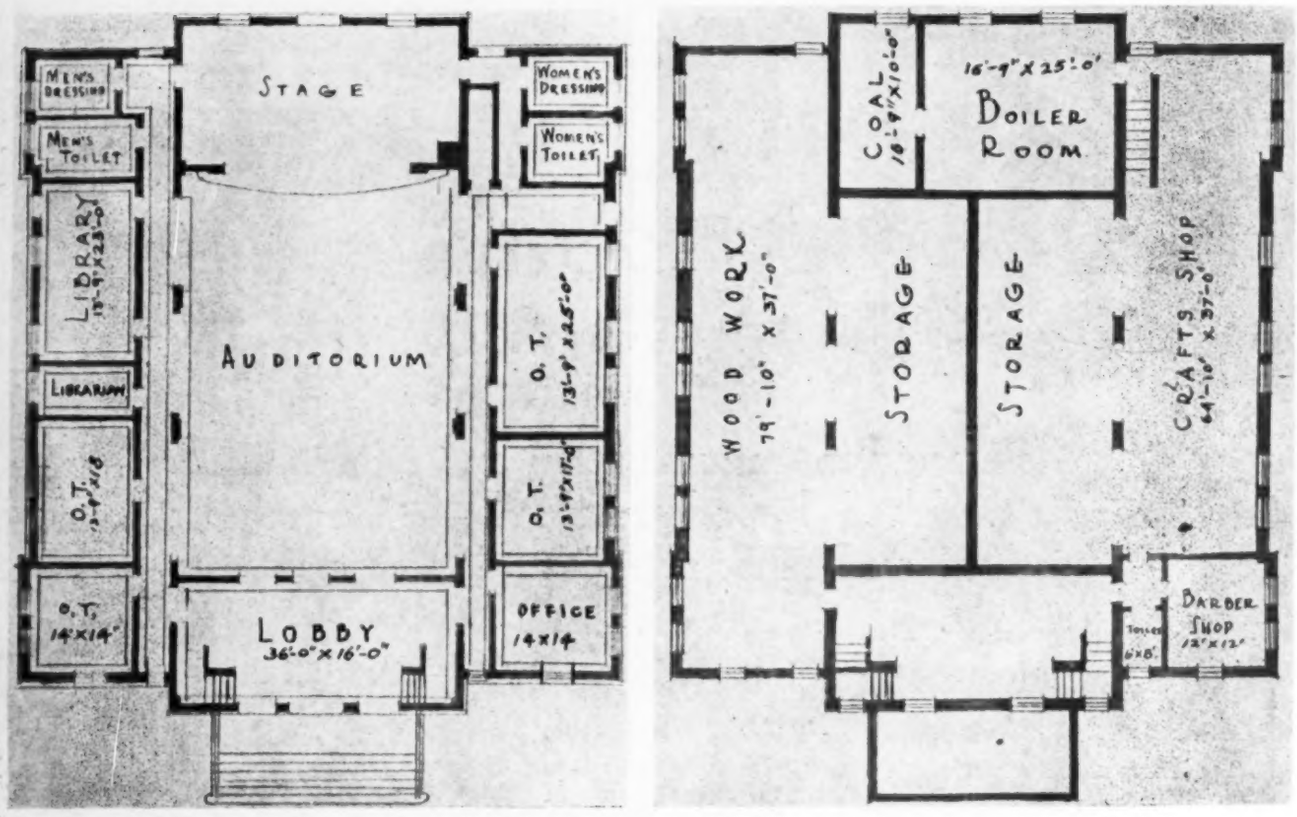

First and second floor plans, occupational therapy building, U. S. Veterans' Hospital, North Little Rock, Ark

The aide or instructor studies the personality of the patient, ascertains his tastes, previous education, experience, and occupation, and within the limitations prescribed by the medical officer applies the form of occupational therapy which seems indicated. In many cases the prescription is made even more definite by the medical officer. During treatment the aide or instructor carefully observes the patient for the development of any condition, physical, mental, or emotional, which indicates that the occupation either as to duration or form is producing other than the desired results.

In writing the prescription the first consideration is the therapeutic benefit to be derived from the occupation, but the medical officer is expected to keep in mind the economies of the situation, and, so far as consistent with the therapeutic indications, to prescribe occupations which will be of assistance to the man in his after life.

Many of the veterans, because of service disabilites, are unable to return to the vocation followed prior to entering service, and Congress has made generous provision that the ex-service man, industrially handicapped through wounds or disease incurred in line of duty, should have the privilege of being trained for some vocation wherein the handicap will be less, or if possible, entirely absent. For instance, a man who was formerly a blacksmith and who lost an arm may be rehabilitated as an accountant and his earning capacity restored. In many cases where a man is to be hospitalized for some months occupations are prescribed which will assist in forming a groundwork for vocational training.

The following lists of occupations have been approved by the Veterans' Bureau for neuropsychiatric patients. This does not mean that all of these occupations are available at each hospital, but it is considered that the list includes a sufficient variety of well-selected occupations to meet the needs of these hospitals.

Form 3634 *Date* .....

REPORT OF OCCUPATIONAL THERAPY FOR MONTH OF .....

Station ..... (Name and number.) (Street.) (City.) (State.)

To THE DIRECTOR, U. S. VETERANS BUREAU, Washington, D. C.

1	2	3											4	5
Name	Days worked.	Textiles.	Reed and Cane.	Woodworking.	Leather and Bookbinding.	Cement and Plastic.	Drawing and Painting.	Academic.	Commercial.	Agriculture.	Metal Work.	Other O. T. subjects.	Number of patients.	Total hours.

SUMMARY TOTAL .....

NOTE.—In entering the totals of items (a) and (b), count each man only once instead of giving the sum of the first five columns under "Occupational Therapy."	U. S. HOSPITAL PATIENTS.	OCCUPATIONAL THERAPY.					
		On wards.		Off wards.			Total (see note).
		Text-books.	Craft.	Class-rooms.	Shops.	Farm.	
(a) Number of patients during month							
(b) Number in last of month							
(c) Number of hours in							

Approved and forwarded:

..... *In Charge of Occupational Therapy.*

..... *Medical Officer in Charge*

Figure 3.

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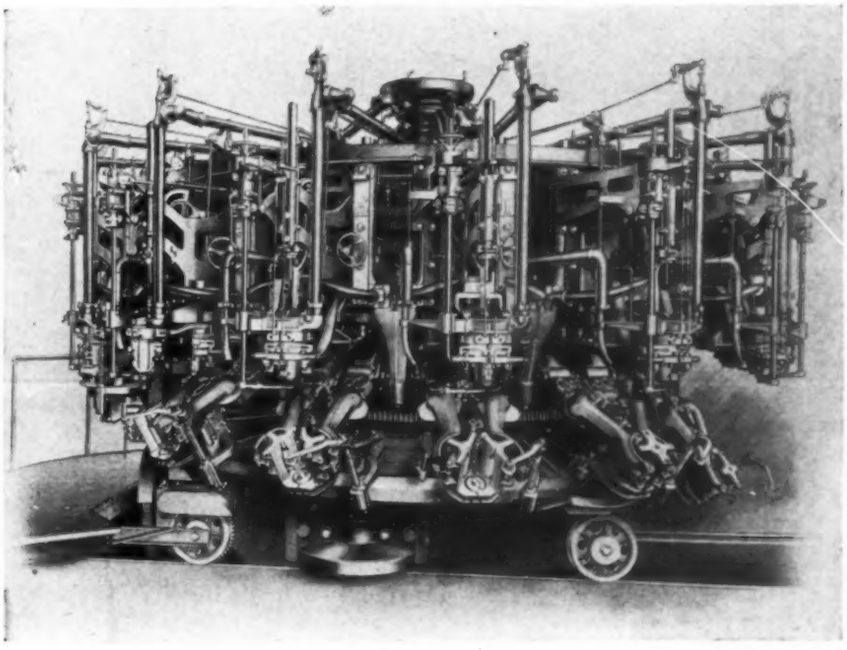

A Bit of Bottle History

SOME 6,000 years ago, glass products were first used in Egypt. The Egyptians, we are told, invented the blow pipe and created our first bottles. For centuries the blow pipe and human lungs were the accepted method of manufacture. Little advancement was made until 1899 when Michael J. Owens conceived the idea of his first bottle machine.

Today, through American ingenuity, the Owens Bottle Machine has developed into one of the world's mechanical marvels. The machine pictured weighs 105,000 pounds. Keene Sumner in the American Magazine refers to it as, "An appalling creature with 9,576 separate parts. It feeds itself with a fiery fluid of molten glass; sucks it up, methodically clutches it with iron hands, blows its breath into it, releases its grasp, nonchalantly drops a finished bottle and moves on to take another gulp."

Due to their process of manufacture Owens Bottles are unequalled for accurate capacity, uniform construction and lustrous glass. There are numerous styles particularly suited to hospital use. Ask your jobber about Owens.

Owens
BOTTLES

THE OWENS BOTTLE COMPANY—Toledo

CLINICAL RECORD

OCCUPATIONAL THERAPY

PART A

WARD ..... AIDE .....

DIAGNOSIS .....

MENTAL ATTITUDE .....

PRESENT CONDITION .....

PROGRESS .....

NOTE.—Part A will be completed by Ward Surgeon. Part B will be completed by aide, initialed by head aide, signed by person in charge of Occupational Therapy, and forwarded to Ward Surgeon for filing.

ASSIGNMENT TO WORK		HOURS DAILY
Light	Ward Work, Crafts	
Active	Ward Work, Mental	
Indoor	Workroom, Groups	
Outdoor	Workroom, Individual	

Date .....

PART B *Ward Surgeon*

MONTH	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	TOTAL
WARD — Academic																																
WARD — Commercial																																
WARD — Crafts																																
SHOP WORK — Group																																
SHOP WORK — Individual																																
Classroom																																
Farm																																
TOTAL																																

MONTH	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	TOTAL
WARD — Academic																																
WARD — Commercial																																
WARD — Crafts																																
SHOP WORK — Group																																
SHOP WORK — Individual																																
Classroom																																
Farm																																
TOTAL																																

Projects completed .....

Rating of project .....

Final disposition ..... Date ....., 19..

....., *Aide*
(Initials only)

In Charge of Occupational Therapy

(Surname) (Given name) (Class of beneficiary) (Compensation No.) (Register No.)

OCCUPATIONAL THERAPY

Figure 4.

For Psychoneurotics

Crafts
- Brass and copper
- Celluloid
- Leather
- Modeling and pottery
- Reed and cane
- Textiles

Academic and commercial studies
Commercial art
Music
Agriculture and allied activities, such as animal husbandry, gardening, poultry raising and bee keeping
Printing
Woodworking
Shoe repairing
Cement and metal work

For Psychotics

Agriculture and allied activities as noted above
Shoe repairing
Tailoring (repairing only)
Woodworking
Cement and metal work
Music
Crafts
- Brass and copper
- Leather
- Reed and cane
- Textiles

Especial emphasis is placed on out-of-door occupations of a masculine type. Station duties such as care of lawns, drives and quarters, work in the laundry, bakery, kitchen, power plant, doing station painting and repair work are often found to furnish the best form of occupational therapy. A portion of a circular recently issued reads as follows:

"The object of hospitalization of psychoneurotics is to expedite social adjustment, and occupational therapy should be prescribed primarily from the therapeutic and secondarily from the pre-vocational or pre-industrial standpoint.

"In veterans' hospitals for psychotics certain patients will be hospitalized for long periods. It may be possible to give systematic instruction in institutional occupations to some of these men so that they may act as assistants to the plumber, auto mechanic, painter, farmer, gardener, poultry man, carpenter, greenhouse man, laundry man, and baker. In writing the prescription the medical officer should take into account the native ability and experience as well as the mental defect of the patient. *Manual labor should not be prescribed for psychotics as a routine matter, but occupations should be given which will meet the therapeutic indications, and at the same time, so far as practicable, enable the patient to fit into the maintenance program of the hospital. The primary objective of occupational therapy is the welfare of the patient.*"

In some of the hospitals deteriorated patients of untidy personal habits are given special instruction in habit training classes. The results of such training have been very encouraging. With less deteriorated cases occupational therapy is used to inhibit the tendency toward psychic disintegration, and thus prevent the occurrence of marked mental degeneration. This is effected by inducing regularity of habits and by interesting the men in something outside of themselves. Regularity of habits, both personal and occupational, has been found of especial value.

Adjusting the Occupation to the Case

Aides with special training bring various crafts to the patients in the closed wards. The psychotic patient with

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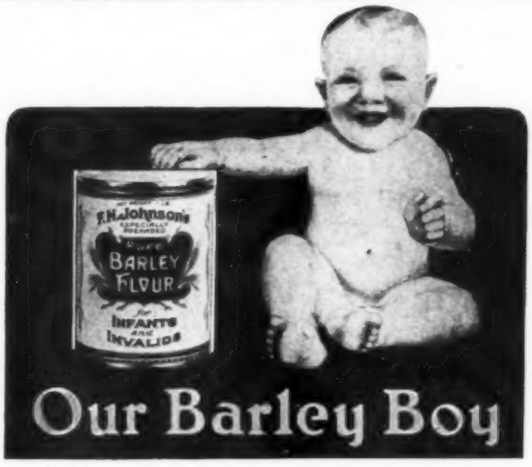


Barley Builds Better Babies!

BARLEY—the food of the gladiators, the fighting ration of the armies of antiquity, Caesar's choice dish, the bone and muscle builder of the ages, the King of grain foods for centuries.

The importance of Barley Water in infant feeding has long been recognized. As a simple, highly beneficial, and easily assimilable nourishment for invalids, Barley is steadily growing in favor among physicians, dietitians, and nurses

JOHNSON'S PURE BARLEY FLOUR, an American product, carefully milled from selected American Barley, provides this valuable food in a form especially adapted to the needs of infants and invalids.

There are many delectable ways of serving JOHNSON'S PURE BARLEY FLOUR to patients—ways which supply appetizing, health-building dishes for young and old.

FREE TO HOSPITALS

A full-sized can of JOHNSON'S PURE BARLEY FLOUR and also a package of CREAM OF BARLEY, will be sent Hospital superintendents or dietitians free upon request.

American Barley Sales Corporation
77 West Washington St.
CHICAGO

CREAM OF BARLEY

Carefully milled from the whole Barley grain, served with cream and sugar provides a perfectly balanced, highly nutritive food, especially valuable for growing children, invalids and those suffering from malnutrition.

Served as a breakfast cereal it has a delicious, rich, nutty, fascinating flavor.

What U.S.P. is to drugs ALL-BRAN is to bran foods

MANY physicians endorse Kellogg's ALL-BRAN heartily. It is used constantly in hospitals because it is ALL-BRAN.

One reason is that they can be sure of the contents of Kellogg's ALL-BRAN. When they recommend it, they know that the anticipated results will be accomplished. Whether the cases are mild or chronic, doctors and nurses can always rely on ALL-BRAN for natural relief.

A second reason for the dependability is that patients don't "forget" to take Kellogg's ALL-BRAN. Cooked and krumbled by a special Kellogg process, it has a most appetizing flavor. It is crisp, nut-like, delicious. It is a really enjoyable breakfast dish!

Kellogg's ALL-BRAN is sold by all grocers.

Kellogg's

***the original* ALL-BRAN**
—ready-to-eat

destructive tendencies may be taught to tear rags to be made into rugs. After a time he will wind these strips, then perhaps he can be induced to braid or weave rugs. The interest of a depressed patient may be aroused by the bright coloring of the craft materials brought to the ward. This awakening interest is fostered and developed until the whole attitude of the man is changed. It is always the rule by means of occupations of increasing interest and intricacy to carry the patient toward practical worthwhile tasks.

Occupations of the manual type furnish exercise, assist metabolism, and promote sleep. Occupational therapy improves the morale of the men, and recoverable cases improve more rapidly when receiving this form of therapy. Occupational therapy in connection with hydrotherapy is found to be of value with dementia praecox cases to carry them over toxic apathetic periods until they can go out and carry on for a time in the community. In a measure, occupational therapy simulates life outside the institution, thereby helping the patients to make adjustments to institutional life, and assisting those who may be paroled to make social adjustments in the community.

When an ex-service man enters a government hospital for the treatment of tuberculosis he is usually in the active stage of the disease. The first indication is rest of body and mind. Mental unrest may have as harmful an effect upon the patient as physical exertion. In some cases light forms of occupational therapy for brief periods serve to assist the patients to adjust themselves to hospital life and have a favorable effect even in the acute stages.

During this period of clinical activity the patient is taught to be comparatively idle. As the disease becomes quiescent the lost habits of industry must be restored. It is important that as convalescence progresses there should be a corresponding increase in physical and mental activity. More active forms of occupational therapy for longer periods are prescribed by the medical officer, and the patient is brought back gradually to a more normal mode of living. By the time he leaves the hospital he is taking a large amount of exercise through occupational therapy and physical culture.

Occupations Suited to the Tuberculous

The following forms of occupational therapy have been approved by the Veterans' Bureau for tuberculous patients.

Crafts
- Brass and copper
- Celluloid work
- Leather work
- Modeling and pottery
- Reed and cane
- Textiles

Academic and Commercial Studies
- Americanization
- Bookkeeping
- English
- Geography
- History
- Mathematics
- Penmanship
- Physics
- Reading
- Spanish (in southwest)
- Spelling
- Stenography
- Typewriting

Commercial art

Light woodwork
- Cabinet making
- Carving

Light agriculture
- Bee culture
- Floriculture
- Light gardening
- Poultry raising

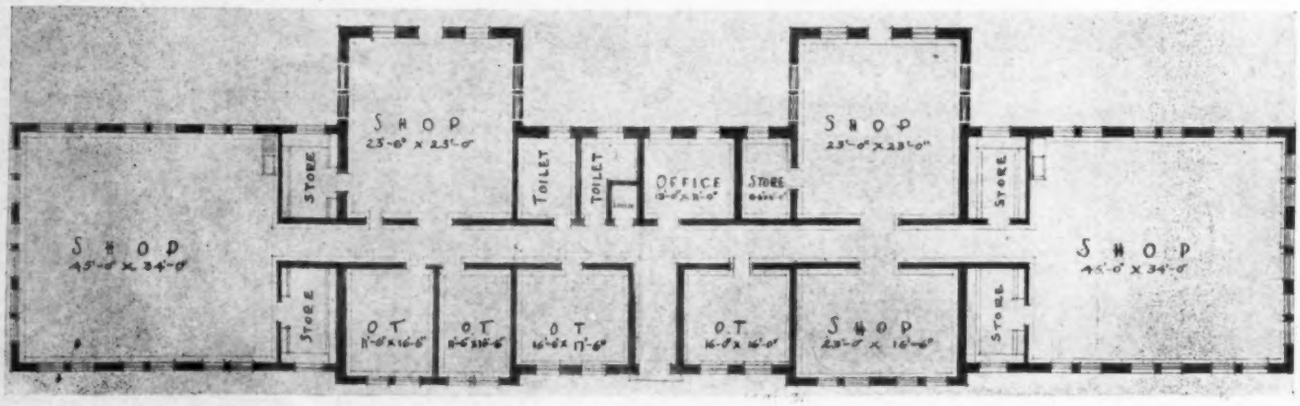
The occupations found useful with bed patients are studies of plant life, drawing, water coloring, rake knitting, light reed work, reading, spelling, letter writing, and kindred subjects.

During the semi-ambulant period more extensive projects in the wards, solariums, or shops, more advanced academic and commercial subjects in class rooms, or short periods of pre-industrial work of various kinds may be prescribed. As the patient reaches the ambulant stage occupational therapy is more specifically directed toward the employment objective. In addition to the commercial and academic subjects, drawing and lettering, gardening, floriculture, and greenhouse operations, bee and poultry husbandry, light woodwork, including cabinet making, wicker work, photography, bookbinding, and leather work are among the subjects prescribed.

Occupational therapy is not usually needed in the general hospitals for such medical and surgical cases as remain but a short period. In some of the general hospitals of this service there are wards occupied by tuberculous and neuropsychiatric patients, and the occupations provided follow the types laid down for these classes of patients.

Practical Treatment in Orthopedic Cases

With many of the orthopedic cases occupational therapy is a very practical form of treatment. Patients with stiff



Occupational therapy building, U. S. Veterans' Bureau Hospital, Perryville, Md.

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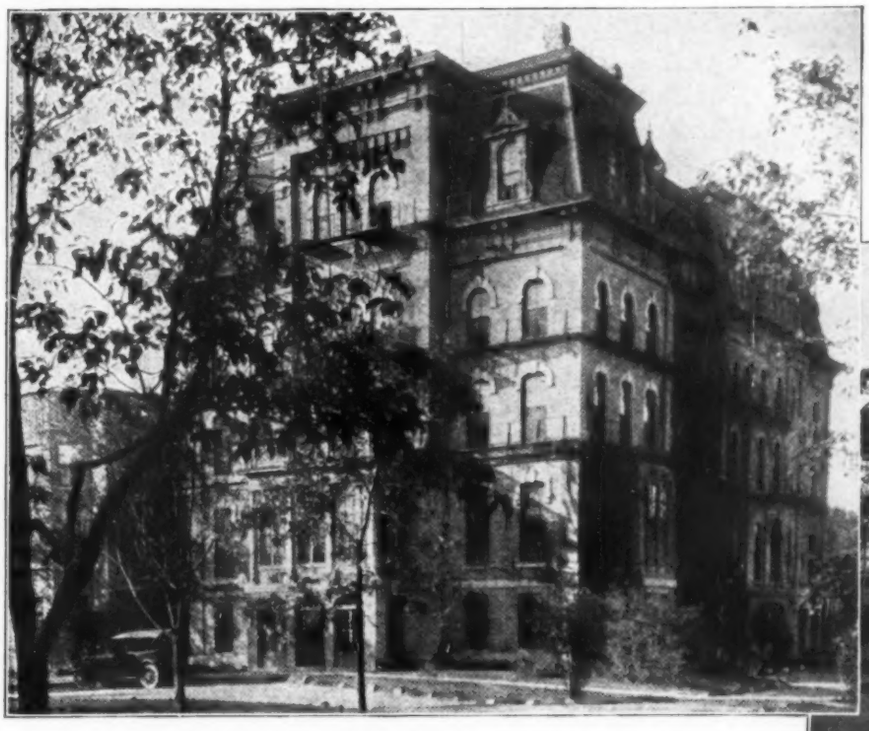

WILLARD HALL, *Northwestern University*

A Campus Path

Mind–*and Body*–Thrive on the Best Food

Nourishment for the body is as important as food for the mind, and schools and universities today exercise due supervision over both. Northwestern University, at Evanston, Illinois, one of the foremost seats of learning in the country, early developed this thought. Its progressive methods are no more clearly illustrated than by the provisions made for housing and feeding its student body.

At Willard Hall, the dormitory for women, as well as at the fraternity houses and dormitories for men, Sexton quality foods are standard. It is the source of great pride to the House of Sexton that it has been serving Northwestern University and its students for so many years.

At Willard Hall, Miss B. I. Gordon is Dietitian, and we especially value her endorsement of Sexton canned foods because of her eminent position among American dietitians.

The need for canned foods of unquestioned quality is not confined to schools or colleges, or to persons of any special age or type. All food served to the public should be the very best. John Sexton & Company was founded for the exclusive service of institutions catering to the public that they might have a constant and dependable supply of quality foods at all times.

If you have never tried Sexton foods and Sexton Service, you could choose no better time than right now to test both.

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fingers and wrists may be given clay modeling and weaving on hand looms to loosen adhesions. The patient with partial fibrous ankylosis of the knee may be given work on a velocipede jig saw, having the pedals so set as gradually to extend the limit of motion of the joint. When regeneration follows a nerve suture occupations which necessitate the use of the group of muscles affected will assist in the recovery. Often because of their interest in the work patients will take indicated exercise in occupational therapy where if the same motions must be accomplished simply as calisthenics they would become weary and neglect the treatment.

It is important that the shops and classrooms be light, dry, and well ventilated and that they be conveniently located so that the patients, particularly in the tuberculous hospitals, may have easy access to them from the wards. The rooms should not be too small, as the personnel cannot supervise the activities of a sufficient number of patients where the space is confined.

The amount of floor space devoted to occupational therapy differs with the type of patients under treatment. In the tuberculosis hospitals 30 to 50 per cent of this treatment may be given in the wards or in solariums. In neuropsychiatric hospitals a limited amount of occupational therapy is carried on in the closed wards, but by far the larger part of this therapy is given in shops and about the hospital and reservation.

The attractive occupational therapy building at the new 268-bed tuberculosis hospital at Livermore, Calif., is built in mission style (page 90). Some 3,750 square feet of well-arranged floor space is provided.

Hospital No. 60, Oteen, N. C., which is a 1,200-bed tuberculosis hospital, has the largest occupational therapy department in the service. Over 5,000 square feet of floor space is made available for this activity (figure 5).

The plans of the occupational building for the 790-bed neuropsychiatric hospital at Federal Park, Md., provide about 6,000 square feet of floor space (page 92). This hospital has been operated at 500-bed capacity with the occupational therapy building as shown in the central part of this drawing. The two wings containing large shops and storage space are needed to care for the additional patients.

The occupational therapy building (page 94) at the neuropsychiatric hospital, No. 78, North Little Rock, space for the hospital library, and over 5,000 square feet of floor space for occupational therapy. This hospital is rated 587 beds.

In U. S. Veterans' Hospitals there are approximately 270 occupational therapy aides and instructors, or an average of one to forty-four patients. In the neuropsychiatric hospitals the average is one to forty-nine; in the tuberculosis hospitals one to thirty-seven; and in the general one to fifty-five. Beds in government hospitals are not yet sufficient in number or rightly located to meet the needs in all parts of the country, consequently many beneficiaries are hospitalized with state and private institutions under contract. Some eighty-five aides and instructors on the bureau pay rolls are assigned to such hospitals in order that occupational therapy may be available for these men.

The average number of occupied hours per month of patients in U. S. Veterans' and contract hospitals under the guidance of bureau occupational therapy employees during the first quarter of 1924 was 313,514, which is fairly representative of the work accomplished each month. Many useful and interesting articles, such as reed baskets and trays, rugs, leather bags and book covers, brass and copper trays and book ends, tin and wooden toys, are made in the course of occupational therapy. It is impressed upon both instructors and patients that these are simply by-products, that the beneficial result on the patients is the objective in giving occupational therapy. However, these by-products have a commercial value. When made in whole or in part from government material, they are government property. Some are sold for the cost of material to the patients who make them. Others not desired by the makers are sold to the public at a fair market price. The amount received by the government during the fiscal year 1924 for these by-products was about $54,000.

Occupational therapy as carried on by the army prior to the time when the care of ex-service men was transferred to the U. S. Public Health Service proved of such material benefit that it has been continued in the army hospital. Experience in the Public Health Service and in the Veterans' Bureau has served to establish more firmly the fact that occupational therapy is a valuable form of treatment in many chronic cases when it is given by trained personnel under careful and intelligent medical supervision.

THE ROLL CALL

Connecticut

The Connecticut Occupational Therapy Society was organized on November 20, 1924. The officers are: president, Miss Kathryn H. Root, Stamford; vice-president, Dr. Otto G. Wiedman, Hartford; secretary-treasurer, Miss Elizabeth Renshaw, Noroton. Members of the executive committee are: Mrs. C-E. A. Winslow and Mr. John B. Dawson, New Haven.

The following constitution was adopted:

Name—Connecticut Occupational Therapy Society.

Purpose—To study occupational therapy and encourage its constructive use for the benefit of the sick and handicapped.

Members—All persons interested in the scientific development of occupational therapy.

Officers—President, vice-president, secretary-treasurer. These with two additional members shall constitute the executive committee. There shall be an advisory board of not more than twenty members, active in medicine, nursing, mental hygiene, social service, philanthropy, art and craftsmanship. All officers shall be elected annually.

Meetings—There shall be at least one meeting annually at the call of the executive committee.

Dues—There shall be annual fee of $1.00 for general, and $5.00 or more for supporting membership, payable in advance from October 1.

Activities—Plans for the work of the society shall be formulated by the executive committee in consultation with members of the advisory board and voted upon at a regular meeting.

Mr. T. B. Kidner, president, American Occupational Therapy Association, delivered an address on "The Spirit and Methods of Occupational Therapy." About forty were present at this first meeting.

Maryland

The first meeting of the season of the Maryland Association was held at the Baltimore Art Museum in conjunction with the Baltimore Handcraft Club. Mrs. Rand of Washington gave a most interesting talk and exhibit of Javanese batik. The general feeling of the members of the Baltimore Association was that it is very stimulating to meet with other organizations having allied interests.

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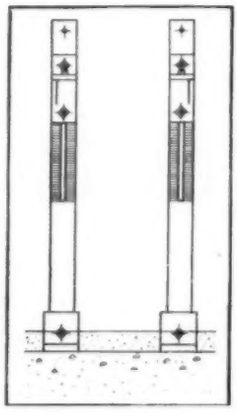

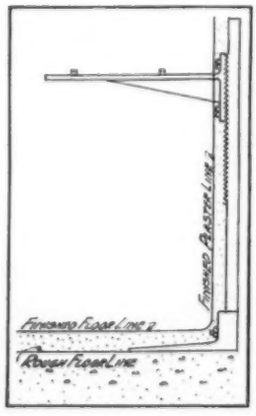

THE Clow Adamantose Instrument Wash Lavatory offers many conveniences. It has besides the oval basin, two self-draining instrument trays. It has knee-operating valve and also a valve regulating volume, in the supply pipe. It is 24 x 36 inches in size.

It is supported on the Clow Adjustable Floor Stand Hanger, which is concealed, and which does away with legs or pedestal. It allows the setting of the lavatory at just the height desired instead of having to accept a standard height.

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Massachusetts

Miss Eleanor Clarke Slagle, secretary-treasurer of the American Occupational Therapy Association, was one of the speakers of the afternoon, at the annual meeting of the Massachusetts Association of Occupational Therapy.

Boston School of Occupational Therapy

The graduating exercises of the Boston School of Occupational Therapy took place on December 5. An interesting program with Mr. Thomas B. Kidner, president, the American Occupational Therapy Association and the Rev. Henry K. Sherrill as speakers, was planned, together with a supper and exhibition of the students' work. Owing to the sudden death of Dr. Walter E. Fernald, president of the board, the directors and graduating class cancelled the plans for a formal graduating exercises and a very simple service, for the awarding of the diplomas, was held in the school rooms.

Pennsylvania

The welfare department of the commonwealth of Pennsylvania has added to its staff—Miss Elizabeth Miller as nursing consultant and Mrs. Martha Magee as social service consultant. These two women will place social service workers and raise standards of nurse training schools, etc. They cooperate closely with occupational therapy work and the three lines of effort together will raise the standards of occupational therapy.

Miss Anna Burns went to Hillside Home, Scranton, to open up an occupational therapy department, December 1.

Two years ago Allentown was the only state hospital with an organized occupational therapy department of graded classes. Miss Putman, state occupational therapist, held a luncheon conference, November 29, with representatives from six institutions where occupational therapy is now organized. They were: Miss Taylor, State Hospital, Norristown; Miss Walter, State Hospital, Allentown; Miss Valtz, State Hospital, Danville; Mrs. Acheson, State Hospital, Harrisburg; Miss Lynch, County Hospital, Retreat; Miss Burns, County Hospital, Hillside Home, Scranton.

Wisconsin

The Wisconsin Occupational Therapy Association had the pleasure of entertaining Dr. H. A. Pattison, medical director, National Tuberculosis Association, at the annual meeting of the Wisconsin association, Dr. Bellis of Muirdale was elected honorary president; Miss Hilda B. Goodman, acting president; Miss Mabel Trame, vice-president; Miss Heinrich, recording secretary; Miss Greison, corresponding secretary, and Miss Blanche Coey, treasurer.

DR. WALTER E. FERNALD DIES

It is with deep sorrow that the editors announce the death of Dr. Walter E. Fernald, Waverly, Massachusetts. Dr. Fernald's death is a keen loss to his many friends and to those who had the privilege of working with him. To those who did not know him personally, his name is nevertheless beloved as one of the pioneers in occupational therapy.

He was elected president of the corporation and board of directors at the fall meeting of the Corporation of the Boston School of Occupational Therapy held at the offices of the school, 7 Harcourt street, Wednesday, November 12.

Dr. Fernald had long been intimately associated with the activities of the school, and had served on the board and was one of the original members of the advisory committee when the school was started at the request of General Gorgas, surgeon general of the army, for the purpose of training occupational therapists for the military hospitals in France.

CLEVELAND O. T. CHAPTER EXHIBITS AT OHIO STATE MEDICAL MEETING

For the first time in its history, an exhibit of occupational therapy was held at the Ohio State Medical Society's semi-annual conference at Hotel Winton, Cleveland.

The Cleveland Occupational Therapy Chapter feels it has advanced one step forward. The Association for the Crippled and Disabled in Cleveland started the movement. They were told by the Academy of Medicine that occupational therapy was so new that few of the doctors would be interested even in an out-of-town speaker. The association wondered what step to take next, as it realized Cleveland needed to be educated along certain lines, such as occupational therapy. They heard of the state conference and tried to arouse some interest among this group. After corresponding for some time and just a month before the conference, the association learned that two booths had been allotted them for an exhibit.

In March, the Cleveland Occupational Therapy Chapter, was organized and the arrangements for the exhibit were turned over to the Cleveland chapter. An attempt was made to give an idea of what is being done in Cleveland. Miss C. Ferguson lent an interesting group-three series of work by manic depressive cases—two of the group by patients in manic state and the third showed the depressive phase. A brief history of each case accompanied each series. This work was of much interest to the delegates.

Rainbow Hospital, a convalescent hospital for crippled children sent in six well-made articles, representing clay work, weaving, needle work, and raffia baskets. The display from City Hospital of Cleveland, where occupational therapy is given on the psychopathic wards only, created much interest. They exhibited some articles showing what use can be made of what so often is regarded as waste materials. They exhibited about ten articles in all, which gave an idea of the variety of work.

The Association for the Crippled and Disabled, which works extensively with shut-ins, had two of its clients working during the day. An Italian who broke his back in 1918, was showing how foot-power weaving had strengthened his legs. He worked very faithfully on a Lane loom, weaving rugs. Another client, paralyzed on his entire right side, worked at short intervals on a basket, which was so arranged as to revolve on a board clamped to a table. This man, before being given home work, sat at home idle. Our object in exhibiting his work was to show the possibilities of such cases.

The exhibit lasted three days, and the different workers from the hospitals exhibiting took turns on duty at the booths to explain the display to many of the physicians. A brief history of every patient was attached to every article.

DR. DUNTON TO DIRECT HARLEM LODGE

Dr. William Rush Dunton, Jr., for over twenty years medical director of the Sheppard and Enoch Pratt Hospital, Townson, Md., has taken over the medical directorship of Harlem Lodge, Catonsville, Md., a sanatorium for mental and nervous patients.

Adv. page 70

Fifth Avenue Hospital, N. Y. C., and photograph of corridors with Johns-Manville Acoustical Treatment.

At the Fifth Avenue Hospital

BELIEF in the health-giving benefits of restful quiet is firmly held by the men who planned New York City's Fifth Avenue Hospital. Hence their use of Johns-Manville Acoustical Correction to conserve the nervous energy of both patients and personel.

Johns-Manville Acoustical Treatment can be easily applied in any hospital, old or new. It is sanitary and practically unnoticeable. In hundreds of institutions where it has been applied, it is heartily endorsed by hospital authorities.

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News of the Hospitals and Sanatoriums

The department of "News of the Hospitals and Sanatoriums" is prepared each month just prior to going to press, for the purpose of presenting the latest authentic news regarding hospital construction, changes in personnel, and other matters in which the hospital field is interested. So far as we can ascertain, the sources of our information, while not guaranteed, are reliable.

General

Bequests and Donations to Hospitals.—The following bequests and donations have recently been announced: Mount Sinai Hospital, and the United Hebrew Charities, New York, N. Y., each $1,000 by the will of Elias Summerfield, St. Luke's Hospital, New York, N. Y., as a memorial to John and Elizabeth Joralemon, to Presbyterian Hospital, as a memorial to John and Charlotte Hays, each $7,500; to Seaside Hospital, as a memorial to Stephen and Julia Hays, $5,000; to the Harrison Memorial Hospital, Cynthiana, Ky., $5,000 by the will of the former mayor, R. S. Withers. St. Anthony's Hospital, Rock Island, Ill., through the will of the late Naomi Davenport, $25,000; St. John's Hospital, Helena, Mont., through the will of the late Mrs. Margaret Larson, $10,000; Mercy Hospital, Tiffin, Ohio, from the estate of the late Louis Pfeifer $1,000.

Methodist Hospitals Dedicated.—The Rev. Newton E. Davis, corresponding secretary, board of hospitals and homes, Methodist Episcopal Church, announces the dedication of the following hospitals: Richland Hospital, Richland Center, Wis., twenty-five beds; November 26; Wesley Hospital, Wadena, Minn., fifty beds, November 30; Methodist Hospital, Pikeville, Ky., fifty-six beds, December 6.

Hospitals and Additions Recently Opened:—Two new pavilions for the French Hospital, San Francisco, Cal.; nurses' home for the Hillcrest Sanatorium, Topeka, Kan.; new home for the Baltimore Eye, Ear, and Throat Hospital, Baltimore, Md.; new building for Huggins Hospital, Wolfeboro, N. H.; hospital of the Jefferson-Davis Beauvoir Soldiers' Home, Beauvoir, Miss.; dormitory for nurses at the White Cross Hospital, Columbus; new addition for the nurses' home at the Bradford Hospital, Bradford; hospital for the Soldiers' Home, Bristol, R. I.; new tuberculosis sanatorium known as Pinehaven, Charleston, S. C.

Hospitals and Additions Recently Opened.—A new building for the Artesia Hospital, Artesia, Calif.; home for the La Jolla Sanitarium, to be known as Scripps Memorial Hospital, La Jolla, Calif.; three new buildings for the Swedish National Sanatorium, Englewood, Denver, Colo.; a new building for the Children's Hospital School, Baltimore, Md.; new home for the Minniberg Institution, Minneapolis, Minn.; a new Ashton Memorial Hospital, Pipestone, Minn.; new addition for the U. S. Veterans' Hospital, Excelsior Springs, Mo.; home for Polish Girls, New York, N. Y.; wing for the Hospital of the House of Calvary, New York, N. Y.; addition for the Springfield City Hospital, Springfield, Ohio; Albany General Hospital, Albany, Ore.; new Butler County Memorial Hospital, Butler, Pa.; first unit of the new home for the South Dakota State Sanatorium for Tuberculosis, Sanator, S. D.; Jefferson County Tuberculosis Hospital, Beaumont, Texas; Waldo Sanatorium, Seattle, Wash.; new Alderson General Hospital, Alderson, W. Va.; and new Marshall County Tuberculosis Sanitarium, Moundsville, W. Va.

Surgeon General of Navy Reappointed.—Announcement has been made that Rear Admiral Edward R. Stitt, surgeon general of the navy, will be reappointed for another term of four years. The present term expired November 30.

Reserve Hospitals Organized.—Pursuant to instructions of the secretary of war, June 27, 1922, the organization of a general hospital organized reserves, to be known as General Hospital, No. 68 (Boston City Hospital Unit, Boston, Mass.) is hereby authorized. The authorization for the organization of a general hospital, organized reserves to be known as general hospital No. 120 (Detroit College of Medicine, Detroit, Mich.,) is hereby amended to read "General Hospital No. 36."

Authority to Organize Evacuation Hospital Revoked.—Pursuant to instructions of the Secretary of War, authority to organize an evacuation hospital, organized reserves, to be known as Evacuation Hospital No. 19 (Davis-Fischer Sanatorium Unit, Atlanta, Ga.,) is hereby revoked.

Alabama

Montgomery Memorial Hospital to Open January 15.—The Montgomery Memorial Hospital, Montgomery, will open for patients January 15.

California

Addition to Burbank Hospital.—The new addition to the Burbank Hospital, Burbank, is about half completed, according to a recent announcement.

Artesia Hospital Quarters Completed.—Work has been finished on the new building for the Artesia Hospital, Bellflower, and the hospital will soon be open to the reception of patients.

New Relief Home for Aged.—The department of public health is erecting a relief home for the aged and infirm to replace structures that have become unsafe because of age and are now a fire hazard.

New Building for Fresno County General Hospital.—A $40,000 appropriation has been made for the Fresno County General Hospital for a three-story wing to house the out-patient, admitting, and maternity departments for the hospital.

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